Basic and Supplemental Term Life

Administration Manual

State of Washington
Payroll/Personnel/Benefits Offices

RETIREMENT | INVESTMENTS | INSURANCE

VOYA FINANCIAL™

(v. 08/16/2016)

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Welcome

Welcome to Voya™ Financial Employee Benefits. This manual is designed as a reference tool for the State of Washington Payroll/Personnel/Benefits Offices to address questions you may have about the administration of your employee benefits plan. If you do not find the answers you need in this manual or if you prefer to talk to a Voya Financial Employee Benefits associate, please call your Account Executive identified in the Quick Plan Reference. We look forward to serving the benefit needs of you and your employees.

About Voya Financial Employee Benefits

The term life insurance policy is issued by ReliaStar Life Insurance Company (Home Office: Minneapolis, Minnesota), a member of the Voya family of companies.

Quick Plan Reference

Group Name: Washington State Health Care Authority

Your Group Benefit Plan Number is: **12373-1** *Please use it on all correspondence and when requested on forms.*

Your Account Number is:
10 – Two year colleges, The Evergreen State College
20 – State agencies
30 – participating K-12 agencies
40 – political sub-divisions/employer groups
200 – University of Washington
300 – Washington State University
400 – Western Washington University
500 – Central Washington University
600 – Eastern Washington University

Please use it on all correspondence and when requested on forms.

Your Group Anniversary Date is: January 1

Quick Plan Reference continued.

Administration and billing questions: **-General policy and coverage questions** **-Service type requests**	Mary Perreault, Account Executive (local) Voya Financial Employee Benefits Regional Office – Seattle Phone: 206-676-6105 FAX: 860-580-0882 Email: Mary.Perreault@voya.com Rebecca Winters, National Accounts Manager Voya Financial Employee Benefits – Home Office Phone: 612-342-3226 Email: Rebecca.Winters@voya.com	Voya Financial Employee Benefits Regional Office – Seattle 520 Pike Street, Suite 2510 Seattle, WA 98101 Voya Financial Employee Benefits – Home Office P.O. Box 20 Route 2-N Minneapolis, MN 55440-0020
Enrollment administration questions: **-Conversion Requests** **-Change of Beneficiary Requests**	**Customer Service:** Dedicated Phone: 866-689-6990	ReliaStar Life Insurance Company 20 Washington Ave South Route 4-N Minneapolis, MN 55440-0020
Enrollment and Evidence of Insurability forms questions	**Medical Underwriting:** Phone: 612-342-7262 FAX for EOIs & MUW inquiries: 612-342-3913	ReliaStar Life Insurance Company 20 Washington Ave South Route 4-S Minneapolis, MN 55401
To file a claim and/or discuss claim procedures for: **-Life** **-Accidental Death and Dismemberment** **-Accelerated Death Benefit claims** **-Waiver of Premium**	**Voya Life Claims:** Toll-Free Phone: 1-888-238-4840 Fax: 612-492-0662	Voya Financial Life Claims PO Box 1548 Minneapolis, MN 55440
Outreach and Training at The Health Care Authority: **-Questions regarding keying or computer system problems**	Phone: 360-725-0440 Phone: 1-800-700-1555 **TOLL FREE** FAX: 360-725-0771 Email:www fuzeqna.com/perspay/consumer/question.asp	Washington State Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684
Agency Contact Changes	If the agency contact changes, please send an email to **The Health Care Authority** through fuze email and to the Account Executive listed above. Please include the following information: • Your Name, Title • Agency Name • Address • Telephone Number and Fax Number • Email Address	

Ordering Supplies

1. You may go on-line to the HCA website at www.hca.wa.gov/perspay to order supplies, print forms or you may call your Account Executive listed in the Quick Plan Reference section of this manual, if you have questions.

Supplies you may need to request:

Term Life & Accidental Death & Dismemberment Insurance Program booklet (Certificate of Coverage)	HCA 50-126*
Conversion of Your PEBB Group Life Policy Form	147077*
Port Choice Group Life Portability Policy Form	GATPORT06
Beneficiary Designation	114834*
Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form	161989 WA***
Life Insurance Evidence of Insurability Form	165180 WA***
Domestic Partnership – Declaration of Tax Status Form	HCA 50-704*
Amendment to Original Application (nontobacco-user certification)	117064*
Absolute Assignment of Group Life Insurance	114865*
Death Claim	See Website*
Trust Verification	142020*
Accelerated Benefit Claim	121583*
Accelerated Benefit Disclosure Statement	44539WA*
Attending Physician's Statement of Terminal Condition	121489*
Authorization for Release of Health-Related Information	127182*
Consumer Privacy Notice	116249*
Accidental Dismemberment Claim	116486*
Attending Physician's Statement of Dismemberment	116150*
Authorization for Release of Health-Related Information	127182*
Consumer Privacy Notice	116249*
Waiver of Premium Disability Claim	115591*
Attending Physician's Statement of Disability	115754*
Authorization for Release of Health-Related Information	127182*
Consumer Privacy Notice	116249*
Voya Financial Life Claims Return Envelopes	115727**

*indicates that a pdf version of this form is available.

**Voya Financial Employee Benefits envelopes are available through the HCA warehouse.

***also available in the back of the Term Life & Accidental Death & Dismemberment Program booklet, HCA 50-126.

Enrollment

Enrollment Period – Newly Eligible Employees

- Newly eligible employees have 60 days from the date they become eligible to apply for benefits to complete a *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form*, and a *Life Insurance Evidence of Insurability Form*, if applicable.
- An employee is eligible to apply for coverage on the date he or she becomes eligible for benefits. For example, an employee hired on February 8 is eligible to apply for insurance coverage on February 8. The 60-day enrollment period would begin on February 8.
- The enrollment form must be completed, signed and received by the personnel, payroll or benefits office no later than 60 days after the employee becomes eligible to qualify for the guaranteed issue amounts without underwriting.
  - Guaranteed issue amounts include:
    - Employee Supplemental –
      - For employee's under the age of 60 – up to $250,000 in $10,000 increments
      - For employee's age 60 or older – up to $100,000 in $10,000 increments
    - Spouse and Dependent Basic – $2,500 per person
    - Spouse Supplemental – up to $50,000 in $5,000 increments (Not to exceed 50% of requested employee supplemental)
    - Accidental Death & Dismemberment – up to $250,000 in $25,000 increments
- Enrollment forms that involve guaranteed issue coverage *only* do not require evidence of insurability when applied for no later than 60 days after the date of eligibility.
- Eligible employees must be actively at work as defined in the *Term Life and Accidental Death & Dismemberment Insurance Program* booklet.

Enrollment Period – Employees Regaining Eligibility

- Employees who regain eligibility upon returning from an approved leave **must** complete a *Life and Accidental Death and Dismemberment (AD&D) Insurance* form no later than 31 days after regaining eligibility.
- If the employee self-paid their supplemental life insurance, the level of coverage self-paid is reinstated without evidence of insurability.
- If the employee chose not to self-pay their supplemental life insurance while on leave, the employee must submit a *Life Insurance Evidence of Insurability* form to ReliaStar for carrier approval to reinstate supplemental life insurance.
- Employees, who do not submit the required forms within 31 days of regaining eligibility, enroll the employee in basic life insurance only. Dependents will not be enrolled.

Enrollment Process

Follow these steps to enroll the employee:

1. Employees may access the *New Employee Enrollment Guide* on the PEBB website: www.hca.wa.gov/public-employee-benefits. If the employee does not have internet access provide a *New Employee Enrollment Guide* to any insurance-eligible employee immediately. The *New Employee Enrollment Guide* includes information about life and accidental death & dismemberment insurance and the *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form*. The guide will direct employees to the PEBB website or their personnel, payroll, or benefits office for a copy of the *Term Life and Accidental Death & Dismemberment Insurance Program* booklet.
2. Have the employee complete the *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form* and return it to you. If no coverage is requested, the employee still needs to complete the form to designate a beneficiary for basic life insurance coverage.

   Note: If there are religious reasons why the employee must waive basic life insurance benefits, please have the employee submit a signed statement in writing and place the statement in the employee's file.

3. Review the enrollment form for accuracy and completeness *(see appendix for sample form)*. Make sure that a beneficiary has been designated and that the form has been signed and dated. The employee should refer to examples in the *Term Life and Accidental Death & Dismemberment Insurance Program* booklet or on the *Beneficiary Designation* form. **Agencies must complete Section 1 of the enrollment form.**
4. Review the enrollment form to determine if underwriting by the insurance company is required.
5. If underwriting is required, provide the employee with a copy of the *Evidence of Insurability* form. Personnel, payroll or benefits office should complete the following parts of the form prior to providing the EOI form to the employee. Complete section A. Complete the employee name in section B. Complete section C, column B. Sign and Date the Confirmation at the bottom of section C. *(refer to page 19)*

   Underwriting is required under the following conditions:

   i. When applying within 60 days of eligibility and requesting an amount in excess of the guaranteed issue amount (listed in the previous section) for employee supplemental. Only the amount in excess of the guaranteed issue amount requires approval.

   ii. When requesting any amount of employee supplemental after the initial 60 days of eligibility.

   iii. When applying within 60 days of eligibility or the date of marriage or registration of the partnership and requesting an amount in excess of the guaranteed issue amount for spouse supplemental. Only the amount in excess of the guaranteed issue amount requires approval.

   iv. When requesting basic spouse more than 60 days after the initial date of eligibility or the

date of marriage or registration of a domestic partnership.

v. When requesting any amount of spouse supplemental more than 60 days after the initial date of eligibility or the date of marriage or registration of a domestic partnership.

*NOTE: Basic dependent child and supplemental AD&D coverage do not require approval.

6. If underwriting is required, the employer does not need to submit a copy of the enrollment form to Voya Financial Employee Benefits; however, they should make sure that they complete the employer portion on both the enrollment and evidence of insurability forms. The employer can submit the *Evidence of Insurability* form to Voya Financial Employee Benefits, however for confidentiality reasons; the employee may want to complete the *Evidence of Insurability* form after the employer has completed their portion of the form and then submit the form directly to Voya Financial Employee Benefits. The address for form submission is on the form. *(refer to page 19)*

   Retain the original enrollment form in your files. The employee may elect to send the *Evidence of Insurability (EOI) Form* directly to Voya Financial Employee Benefits.

7. **State agencies** – Key the enrollment/changes in the insurance system.

   Note: If the employee applies for more than the guaranteed issue amount(s), in the insurance system key the guaranteed issue first. After the guaranteed issue amount moves to "current coverage", then key the additional amount(s) that require underwriting. Contact HCA if you have any questions.

   Higher education institutions – Key the enrollment/changes in your payroll system.

   Employer groups –

   (a) Who key in the insurance system – Key the enrollment/changes in the insurance system and adjust the premiums in your payroll system.

   (b) Who don't key in the insurance system – Send a copy of the forms to HCA for keying in the insurance system and adjust the premiums in your payroll system.

   A Final Action Notice (FAN) is the document that is sent out by Voya Financial) Employee Benefits Medical Underwriting Department to indicate the status of an application for coverage: approved, denied, or closed.

   Note: For employees being underwritten, **do not begin payroll deductions** for any coverage which requires approval until receiving a Final Action Notice (FAN) from the insurance company indicating approval of coverage.

   Key the approval, denial, or closure in the insurance system upon receipt.

   Transferring Life Insurance – When both spouses or registered domestic partners receive PEBB benefits and one terminates coverage, any in-force *employee supplemental* life insurance can be transferred, without carrier approval, to the remaining insured employee's *spouse supplemental*. The combined spouse supplemental coverage may not exceed one-half of the insured employee's supplemental coverage.

Likewise, any in-force *spouse supplemental* coverage can be transferred, without carrier approval, to the remaining *employee's supplemental* coverage, up to the maximum allowed. Spouse basic may be added without carrier approval if spouse coverage is being transferred.

8. In the event that the terminated employee cannot transfer all of the coverage to their spouse or registered domestic partner's account due to plan maximums, the terminated employee and their dependents may keep the remaining basic and/or supplemental coverage by applying for the Portability Choice Life coverage or by converting the life insurance no later than 31 days after termination. *(If the termination is due to retirement, the employee may also be eligible for Retiree Life Insurance.)* The employee's application for Portability Choice is subject to approval by Voya Financial Employee Benefits (ReliaStar)

   If the employee's application for Portability Choice Life coverage is denied, the employee may convert the remaining balance no later than 31 days after the application has been denied. Only the amount of terminated life coverage may be converted no later than 31 days after the termination date or denial of Portability Choice. Any transfer of coverage under this provision must be immediate and without lapse in coverage. Contact HCA to determine the amount of coverage the spouse or registered domestic partner has at the time of termination.

   Example of Guaranteed Issue Transfer:

Type of Coverage	**Terminating Employee's Amount of Coverage**	**Still Employed Employee's Amount of Coverage**	**Amount After Transfer**
Spouse Supplemental	$50,000	$50,000	$150,000
Employee Supplemental	$150,000	$250,000	$300,000

   The terminating employee's spouse supplemental coverage may be transferred to the active employees' employee supplemental coverage, up to the maximum allowed. In the example above, the terminating employee has $50,000 in spouse supplemental coverage which is transferred to the active employee's employee supplemental coverage for a total of $300,000 in employee supplemental.

   The terminating employee's employee supplemental may be transferred to the active employee's spouse supplemental coverage up to the maximum allowed and must be in increments of $10,000. The maximum spouse supplemental allowed is one-half of the employee's employee supplemental and must be in increments of $5,000. In the example, the terminating employee had $150,000 in employee supplemental. The active employee, after transferring $50,000 has $300,000 in employee supplemental coverage; therefore, spouse supplemental can be a maximum of $150,000. The active employee currently has $50,000 in spouse supplemental. The terminating employee can transfer $100,000 to the active employee's spouse supplemental ($50k + $100k = $150k).

   The terminating employee may apply for Portability Choice or convert the remaining $50,000.

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Effective Dates

Employer-provided Basic Employee Life (employer pays 100% cost of coverage):
"Coverage begins on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then insurance coverage begins on that day (Eligibility for employees of participating Employer Groups is based on the Employer Group's contract with HCA)."

Employee-paid Employee Supplemental Life (employee pays the full cost of coverage):

A. For guaranteed issue coverage requested no later than 60 days after the eligibility date, coverage is effective the first of the month following the signature date on the form. Note: Coverage may not begin prior to the first day of employment.

   - Guaranteed issue amounts include: employee supplemental (up to $250,000 for employees under the age of 60 and up to $100,000 for employees age 60 or older), basic spouse and basic child ($2,500 per person), spouse supplemental (up to $50,000), and supplemental AD&D (up to $250,000).

B. If underwriting is required and coverage is approved, the effective date for the approved coverage will be the first of the month following the approval date on the Final Action Notice received from the insurance company. For agencies that key in the insurance system, key the Final Action Notice. **All agencies** – make any necessary adjustments to your payroll system.

If you enroll your dependents in Basic Life insurance within 60 days of becoming newly eligible, coverage begins on the first day of the month following the day you become eligible. If you become eligible on the first working day of a month, then insurance coverage begins on that date."
If the employee enrolls in basic children life or supplemental AD&D after the initial 60 days of eligibility, the coverage becomes effective the first of the month following the signature date on the enrollment/change form. Basic children and supplemental AD&D do not require approval.

Enrollment – Dependents

Evidence of Insurability (also known as underwriting)

Registered Domestic Partner Coverage
The same levels of coverage and underwriting requirements apply to an employee's registered domestic partner (and their children) as apply to the spouse of an employee.

The employee and registered domestic partner must complete a *Declaration of Tax Status* form, which will be filed along with the employee's enrollment form. If the employee and registered domestic partner have already completed this form for the medical insurance, a separate form will not be required for the life insurance. A copy of this form will be required along with enrollment information when a death claim on the registered domestic partner is submitted.

Enrolling a Spouse/Registered Domestic Partner without Evidence of Insurability
If the employee requests spouse/ registered domestic partner coverage when the employee enrolls in the plan no later than 60 days after the initial date of eligibility, no underwriting is necessary for the dependent coverage, unless the employee requests more than the $50,000 supplemental spouse guaranteed issue amount (not to exceed 50% of employee supplemental). The employee indicates election of dependent coverage on the enrollment form for each type of desired coverage. If the employee doesn't want a particular coverage, such as spouse supplemental, the employee should leave it blank.

Note: The request for spouse/ registered domestic partner coverage in supplemental spouse cannot exceed 50% of the amount of coverage in employee supplemental. For example, if the employee has $50,000 in employee supplemental; the amount of coverage requested in spouse supplemental cannot exceed $25,000.

If a covered employee wants to add dependent coverage no later than 60 days after a qualifying event (marriage, registration of a domestic partnership, new dependent of the registered domestic partner, birth, or adoption), no underwriting is required for the new dependent(s). Basic dependent life (children) never requires approval. Employees must submit a *Declaration of Tax Status Form* for their registered domestic partner and any non-tax qualified dependents.

The *Life and Accidental Death and Dismemberment (AD&D) Insurance Enrollment/Change Form* is used when a newly eligible employee is enrolling in life insurance no later than 60 days after their date of eligibility. An *Evidence of Insurability Form* is required for amounts in excess of the guaranteed issue amounts listed above.

If the employee is enrolling after the first 60 days of eligibility or making a change to their coverage, the employee must submit the *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change form. A*n *Evidence of Insurability Form* may also be required.
Follow these steps to add dependent coverage after the initial 60 days of eligibility:

1. The employer completes Section 1 Agency/Policy Holder Information of the enrollment/change form.

2. The employee completes section 2 Employee Information, Section 3 Employee Life Insurance, Section 4 Spouse/Dependent Life Insurance, Section 5 Supplemental AD&D, Section 6 Beneficiaries, and Section 7 Signature.
3. Review the forms for accuracy and completeness. *(see appendix for sample form)*
4. Provide the employee with a photocopy of the form. Attach the original to the employee's benefit enrollment form in your file.
5. **State agencies** – Key the enrollment/changes in the insurance system.

   Higher education institutions – Key the enrollment/changes in your payroll system.
   Employer groups –

   (a) Who key in the insurance system – Key the enrollment/changes in the insurance system and adjust the premiums in your payroll system.

   (b) Who don't key in the insurance system – Send a copy of the forms to HCA for keying in the insurance system and adjust the premiums in your payroll system.

For Underwritten Spouse/ Registered Domestic Partner Coverage

After receiving a Final Action Notice (FAN) from the insurance company indicating approval of coverage for the dependent(s), file the FAN with the employee's enrollment form or permanent records. For agencies that key in the insurance system, key the Final Action Notice. All agencies make any necessary adjustments to your payroll system.

Terminating Dependent Benefits

If the employee wishes to cancel dependent benefits, follow steps 1 and 2 above. The employee needs to complete a *Life and Accidental Death and Dismemberment (AD&D) Insurance Enrollment/Change Form* indicating the coverage to be continued and the coverage to be terminated. Carrier approval is not required to cancel coverage. For agencies that key in the insurance system, key the change with an effective date of the last day of the month in which the employee signed the form. For employers who do not key in the insurance system, send the forms to HCA for keying. All agencies make any necessary adjustments to your payroll system.

The Following Special Requirement May Apply to Term Life:

Supplemental spouse coverage may not exceed 50% of the employee coverage in employee supplemental. Refer to the *Term Life and Accidental Death & Dismemberment Insurance Program booklet* for the specifics of the plan or contact your Account Executive listed in the Quick Plan Reference section of this manual.

Dependents eligible to apply for coverage under basic spouse and dependent, supplemental spouse, and supplemental AD&D include:

1. The employee's lawful spouse.
2. The employee's registered domestic partner.
3. Children 14 days or older, but under 26 years of age, who meet the definition of dependent as defined in WAC 182-12-260(3).

Evidence of Insurability – Underwriting

Situations Requiring Evidence of Insurability
If the application falls into one of the situations listed below, an Evidence of Insurability (EOI) form must be submitted to Voya Financial Employee Benefits. Coverage can only be made effective if approved by the insurance company.

- Application for employee and/or dependent coverage is signed more than 60 days after becoming eligible, or reinstatement is desired after coverage has been terminated. Basic dependent (children) and supplemental AD&D never requires approval.
- Applicant applies for more employee or spouse/ registered domestic partner coverage than the plan's guaranteed issue life coverage amount within 60 days of eligibility or within 60 days of marriage or registration of a domestic partnership.
- Applicant wishes to increase the amount of employee or spouse/ registered domestic partner coverage currently in force.
- The employee was previously on LWOP (leave without pay) and did not self-pay for his/her coverage.
- An employee is re-hired and coverage was converted when employment was previously terminated.

If coverage needs to be underwritten, payroll deduction for this coverage **should not begin** until a Final Action Notice (FAN) from Voya Financial Employee Benefits has been received indicating approval of the coverage. Any coverage that requires approval should be pended in the insurance system. All agencies should make any necessary adjustments to your payroll system.

Evidence of Insurability
The *Evidence of Insurability* form is available on the PEBB website: www.hca.wa.gov/public-employee-benefits or through the HCA Warehouse.

The employer should provide the employee with a copy of the form with section A, section B employee name and section C, column B completed. Sign and date the Confirmation at the bottom of section C.

Instruct the employee to do **one** of the following with the completed EOI form:

- Send the completed EOI form directly to Voya Financial Employee Benefits (the address is on the form).
- Return the completed EOI form to his/her personnel/payroll/benefits office. The personnel/payroll/benefits office must forward the EOI to Voya Financial Employee Benefits (the address is on the form).

The employee should keep a copy of the completed EOI form for his/her records.

If you have questions regarding the EOI form, contact your Account Executive listed in the Quick Plan Reference Section of this manual.

IMPORTANT!!

- The amount to be underwritten is the dollar amount of coverage for which the applicant must show proof of good health (i.e. be medically underwritten for). The amount to be underwritten does **not** include coverage that can be issued **Guaranteed Issue** and does **not** include coverage already in force or already approved.
- **The employer must complete section 1 of the enrollment/change form. The employer must also determine if evidence of insurability is necessary. If it is needed, complete section A, the employee name in Section B and verify the appropriate amounts are entered into section C, column B of the *Evidence of Insurability* form, then date and sign the form.**
- The "**Current Coverage**" is the dollar amount of coverage that the applicant already has in force and/or can be issued without medical underwriting (guaranteed issue coverage).
- The amount in Section 3, 4, and 5 of the enrollment/change form should always be entered as a dollar amount.
- **Each form supersedes all prior enrollment/change forms.**
- **It is important that the amounts indicated on the evidence of insurability form are correct in order to prevent the requesting of unnecessary underwriting requirements such as exams, blood profiles, EKG's, etc.**

Evidence of Insurability cont.

The Underwriting Process

Voya Financial

Employee Benefits Medical Underwriting Department may take action based only on the information found on the EOI form or may do the following:

- Request an applicant's medical records directly from the applicant's physician or other health care provider.
- Write directly to the applicant requesting additional information.
- Request a physical examination and/or urinalysis, blood profile, EKG, etc.

The applicant will be notified if additional underwriting requirements are needed to process the application.

Final action will be determined provided the EOI is complete and accurate, and no additional requirements are necessary. Depending on the amount of coverage applied for, complexity of the applicant's medical history, and/or delays over which Voya Financial

Employee Benefits has no control, processing time may vary.

The **Final Action Notice (FAN)** is the document prepared by Voya Financial

Employee Benefits showing approval, denial, or closure of the coverage. *(see appendix for a sample FAN)*

- A FAN will be sent to the employee's Agency.
- A FAN will also be sent to the employee.
- Due to confidentiality issues, if an employee is declined for coverage or their file is being closed because medical underwriting requirements were not completed, a FAN will always be sent to the employee indicating the reason(s) for the decline or closeout action. A FAN will also be sent to the agency but the reason(s) for decline or closeout for this employee will not be indicated on the FAN.
- **If the employee is declined or his/her file is closed out (because underwriting requirements were not completed), <u>coverage cannot be made effective</u>.**

Closed Files

Each applicant's file is assigned a closeout date (when the file will be closed if underwriting requirements are not received). The file will be closed if the requested information is not received. Coverage in a closed file cannot be made effective unless a *"Change of Action"* Final Action Notice is received at a later date.

If the necessary underwriting requirements are received after the file has been closed, based on the situation, one of the following will occur:

- An underwriting decision will be made at that time.
- The file will be re-opened and additional underwriting requirements will be ordered.
- If there has been a significant time delay, a new *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form* and *Evidence of Insurability Form* will be requested.

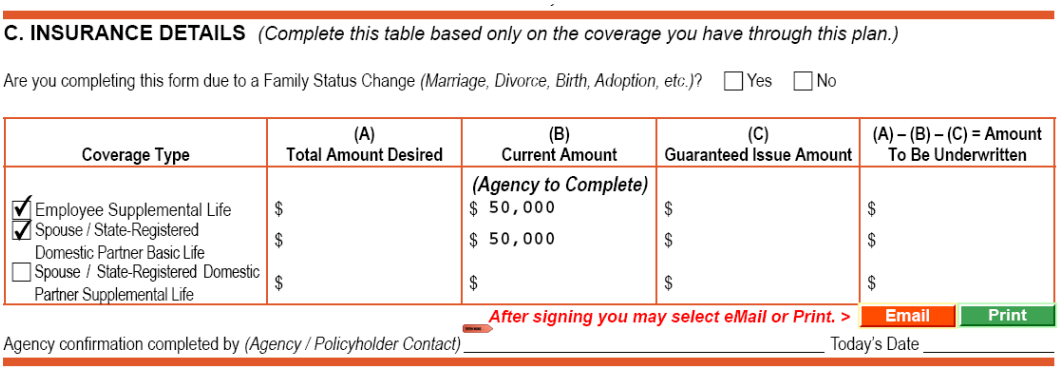
For questions or problems related to specific underwriting cases, you may call (612) 342-7262 or (800) 955-7736. Ext 7262.

If you wish to see an activity report regarding employees in your plan currently being underwritten, please contact your local Account Executive listed in the Quick Plan Reference section of this manual.

Create a Digital ID for the Life Insurance Evidence of Insurability form

You will need to create a digital signature the first time you sign the EOI form electronically. After that your digital signature will be available for use when signing the EOI form.

1. Open the *Life Insurance Evidence of Insurability* form on the PEBB Life Insurance page or the PersPay Forms page.
2. Complete section A, Employee Name in section B, and column B of section C. At the bottom of section C, click in the signature field.



C. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

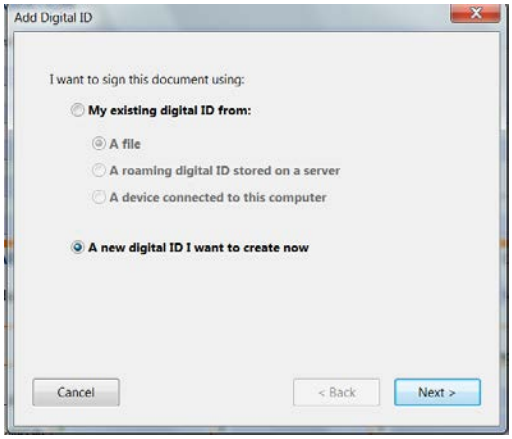
Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
		(Agency to Complete)		
☑ Employee Supplemental Life	$	$ 50,000	$	$
☑ Spouse / State-Registered Domestic Partner Basic Life	$	$ 50,000	$	$
☐ Spouse / State-Registered Domestic Partner Supplemental Life	$	$	$	$

After signing you may select eMail or Print. > Email Print

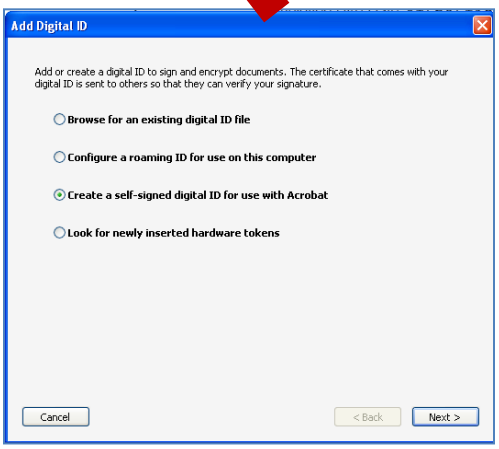
Agency confirmation completed by *(Agency / Policyholder Contact)* _____ Today's Date _____

3. The "Add Digital ID" wizard opens. You will see one of two "Add Digital ID" screens.

(a)

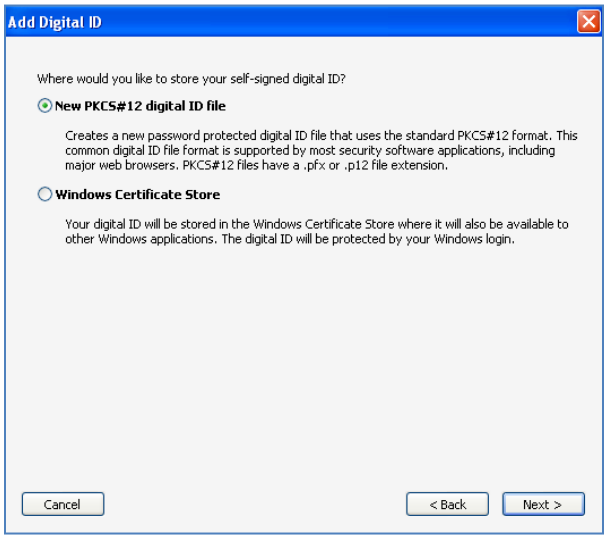


(b)

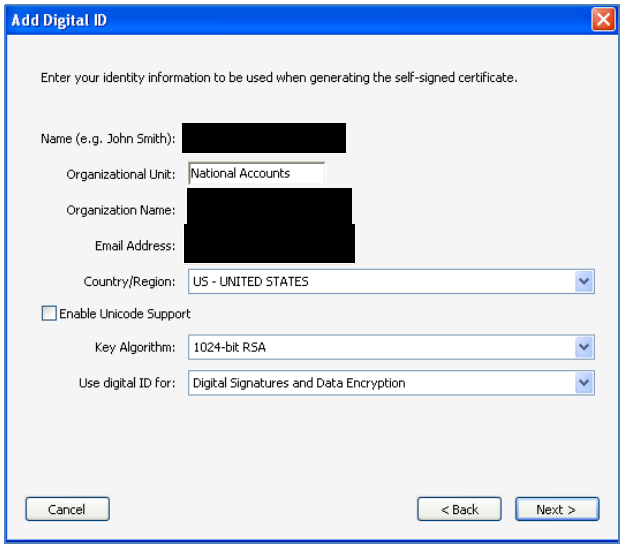


If you see screen (a) above, select the "A new digital ID I want to create now" option. If you see screen (b) above select the "Create a self-signed digital ID for use with Acrobat" option.

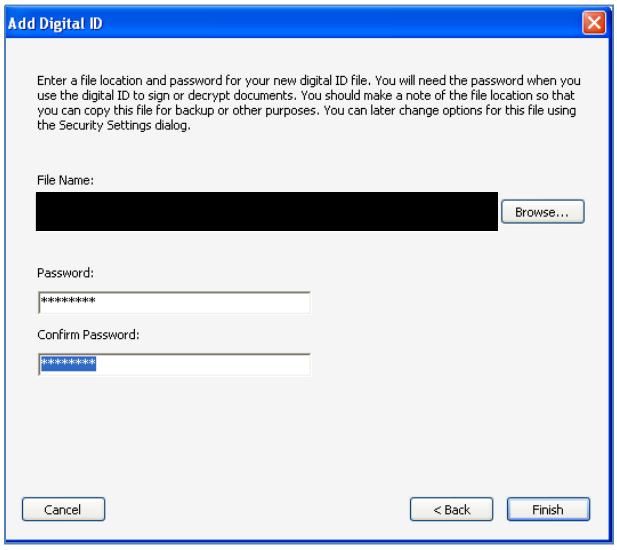
4. Select “Next”. A new screen will open to select where you would like to store your digital ID. Select the first option: “New PKCS#12 digital ID file”.



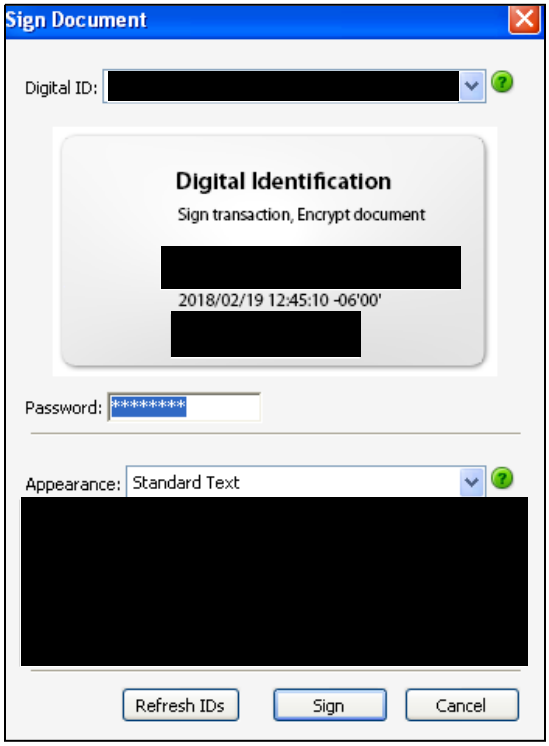
5. Select “Next”. Enter your name, organizational unit, organizational name, and email address in the fields provided.



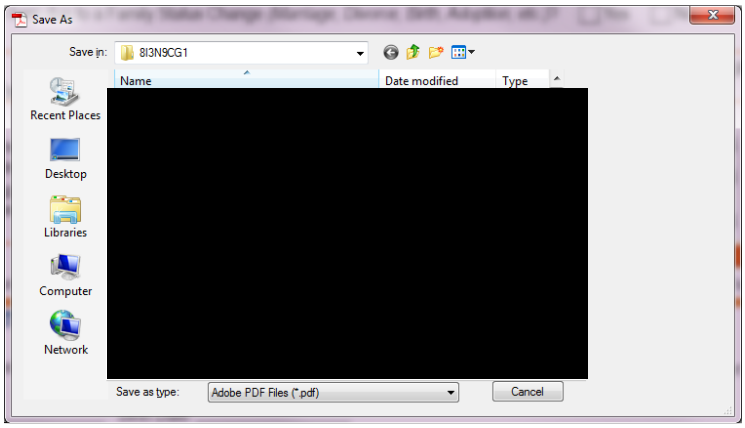
6. Select “Next”. Create and confirm your password. You will need the password to sign documents with your digital ID in the future so make it something you can remember.



7. Select “Finish”. The “Sign Document” window opens. Enter your password in the field provided.

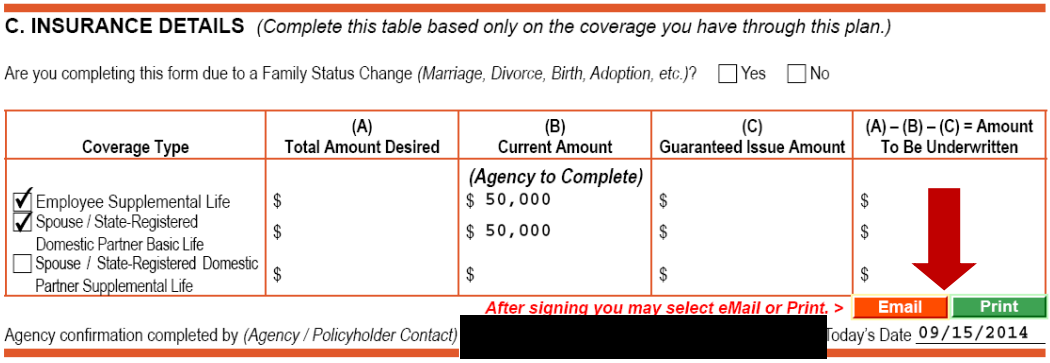


8. Select “Sign”. The “Save As” window opens.



9. Enter a name for your signature file. Select “Save”. The signature is placed in the signature field on the EOI form. Enter the date in the date field.

10. Select the “Email” or “Print” button on the form.



C. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
		(Agency to Complete)		
☑ Employee Supplemental Life	$	$ 50,000	$	$
☑ Spouse / State-Registered Domestic Partner Basic Life	$	$ 50,000	$	$
☐ Spouse / State-Registered Domestic Partner Supplemental Life	$	$	$	$

After signing you may select eMail or Print. > Email Print

Agency confirmation completed by *(Agency / Policyholder Contact)* [redacted] Today’s Date 09/15/2014

Certificate Booklets

The *Life Insurance Certificate of Coverage* booklet is the insured's written record of coverage. The employer will distribute a *Certificate of Coverage* upon request from the insured. Please refer to the certificate booklet for plan design and coverage details.

Supply of Certificate Booklets

Certificates are available on the PersPay website at www.hca.wa.gov/perspay for employers, the PEBB website at www.hca.wa.gov/public-employee-benefits for employees, and through the HCA warehouse.

Distributing Certificate Booklets

The booklets are 'No Name/No Effective Date" certification booklets. This means that it is not necessary to identify the insured's name and the effective date of coverage inside the certificate booklet.

If there are riders indicating changes to the coverage or additional provisions for specific classes of employees, attach the appropriate rider to the certificate booklet prior to distribution. HCA or Voya Financial Employee Benefits will provide them to you so that you may attach the appropriate rider to the certificate booklet.

Additional Stickers and/or Notices

You may receive supplies of stickers and/or notices that are applicable to residents of certain states. Stickers must be attached to the front of each certificate booklet and the notices must be distributed along with each certificate booklet to residents of those states.

Coverage Cancellation by Insured

The insured may request cancellation or reduction of supplemental life coverage at any time.

Processing a request for Cancellation

1. The insured or assignee (if applicable) completes a new *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form*. The form must be dated and signed. (*See Assignment section on page 30.)*

2. **State agencies** – Key the enrollment/changes in the insurance system.

   Higher education institutions – Key the enrollment/changes in your payroll system.
   Employer groups –
   - **(a) Who key in the insurance system –** Key the enrollment/changes in the insurance system and adjust the premiums in your payroll system.
   - **(b) Who don't key in the insurance system –** Send a copy of the forms to HCA for keying in the insurance system and adjust the premiums in your payroll system.

3. The agency/employer should keep the original enrollment/change form in the employee's file and give a copy to the insured/assignee *(see page 30)*.

4. The employer should make any premium adjustments necessary. Refunds cannot exceed 12 months.

If you have questions, contact PEBB Outreach and Training, listed in the Quick Plan Reference section of this manual.

Changes

The *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change form* is required when an employee enrolls in supplemental coverage after the initial 60 days of eligibility, adds a spouse/registered domestic partner, and/or child, removes a spouse/ registered domestic partner, and/or child, changes coverage amounts, transfers life insurance to a spouse/ registered domestic partner, or chooses to reinstate supplemental coverage that was not self-paid during a leave of absence.

See the Evidence of Insurability – Underwriting section of this manual for a list of when an *Evidence of Insurability Form* must also be submitted by the employee.

Name Change

There are several reasons for name changes, such as:

- Marriage
- Divorce
- Court Order
- Name entered on the form originally was incorrect

Requirements when processing a name change:

1. The insured completes a *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form*. The form must be dated and signed. The agency may request a copy of the court order. Indicate "name change only" at the top of the change form.

2. Attach it to the insured's most recent life enrollment/change form and place in the employee's file.

3. If a *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form* is completed indicating "name change only", it does not supersede the prior enrollment/change form.

Change of Address

Follow these steps when processing a change of address:

1. The completion of *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form*, is optional, and if completed, should be clearly marked "address change only" at the top of the form.

2. The employer should attach the form to the insured's most recent life enrollment/change form.

3. If a *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form*, is completed indicating "address change only", it does not supersede the prior enrollment or change form.

If you have questions, contact PEBB Outreach and Training, listed in the Quick Plan Reference section of this manual.

Changes cont.

Non-Tobacco User

An *Amendment to Original Application* form is available to request a change from tobacco-user to non-tobacco user rates. This form must be used to amend the original enrollment form or application. This change does not require underwriting.

New employees or employees who are changing their coverage need to complete the tobacco products questions in Section 2 of the enrollment/change form.

If the employee is already insured and only wants to change his/her tobacco status, the employee needs to complete the *Amendment to Original Application*.

The nontobacco-user rate should become effective the first of the month following the signature date on the *Amendment to Original Application* form.

Follow these steps to make this change:

1. Give the employee the *Amendment to Original Application* to be completed, dated and signed. *(see appendix for sample form)*

Note: To qualify for the nontobacco-user discount, the employee and his/her spouse/ registered domestic partner (if he or she is covered under spouse supplemental) must not have used "tobacco products" within the past 2 months. This includes at least cigars, cigarettes, chewing tobacco, snuff, and other tobacco products. "Tobacco products" does not include US Food and Drug Administration (FDA) approved quit aids or e-cigarettes until their tobacco related status is determined by the FDA. Tobacco use does not include the religious use of tobacco.

2. **State agencies** – Key the change in the insurance system.
   Higher education institutions – Key the change in your payroll system and adjust the premiums in your payroll system.
   Employer groups –
   Who key in the insurance system – Key the change in the insurance system and adjust the premiums in your payroll system.
   Who don't key in the insurance system – Send a copy of the forms to HCA for keying in the insurance system and adjust the premiums in your payroll system.

3. The employer should attach the form to the insured's most recent life enrollment/change form and place in the employee's file.

4. The **effective date is the first of the month following the signature date on the *Amendment to Original Application*. This date may not be earlier than the current coverage effective date.**

5. Make any necessary premium adjustments.

If you have questions, contact PEBB Outreach and Training, listed in the Quick Plan Reference section of this manual.

Beneficiaries

A beneficiary is the individual or entity designated to receive proceeds from the life coverage upon the insured's death.
The insured designates beneficiaries when completing the initial enrollment form for coverage. If there is not enough room on the enrollment form to list all beneficiaries, additional beneficiaries can be named on a separate piece of paper. The insured should list his/her own full name, date of birth, social security number, and group plan number on the sheet of paper, sign and date it, and attach it to the enrollment/change form.
Beneficiary designations should be kept up to date and reviewed when changes in status occur, such as:

- Marriage
- Name change
- Registration of domestic partnership
- Birth or adoption of a child
- Divorce
- Dissolution of domestic partnership
- Death in family

**Advise employees that beneficiaries should be updated after a divorce or dissolution of a partnership. Unless the dissolution, declaration of invalidity or other court order requires that the former spouse/ registered domestic partner remains the beneficiary, no claim may be paid to a former spouse/ registered domestic partner. (RCW 11.07.010)*

Beneficiary Designations <u>Not</u> Allowed

- ⇨ The plan/policyholder cannot be named as beneficiary.
- ⇨ An organization or endowment should not be named as beneficiary unless it is certain that such an organization or endowment is a legal entity (i.e. it has a recognized legal existence such as a corporation, trust or partnership).

Dependent Life Standard Designation

- ⇨ The beneficiary for dependent coverage is always the insured, if living, to whose policy/certificate the dependent coverage is attached. The beneficiary cannot change.

Other Beneficiary Designations

- ■ Trust

  If a trust is named as beneficiary, the name of the trust, trustee, and date the trust was formed must be included on the form. At the time a claim is filed Voya Financial Employee Benefits will request a copy of the trust and a statement from the trustee indicating the trust is in effect and the trustee is willing to act as a trustee. If the named trustee isn't willing to act as the trustee, then the trust can't be the named beneficiary.

- ■ Charity

  If a charity or other organization is named as beneficiary, the city and state of charity or organization must be included.

  Before naming an organization as beneficiary, it should be verified as a recognized legal entity (refer to paragraph, Beneficiary Designations Not Allowed).

Beneficiaries cont.

- **Irrevocable** — An irrevocable beneficiary is one whose interest in the policy cannot be changed or reduced without his/her consent. The wording of the beneficiary designation must stipulate 'irrevocable'. If an irrevocable beneficiary has been named at the time the insured enrolls in the life plan, both the insured and irrevocable beneficiary must sign the enrollment form. To change the beneficiary will require both signatures.

- **Secondary** — A secondary beneficiary is the person designated to receive life insurance policy proceeds if the primary beneficiary should die before the insured dies. Secondary beneficiaries may be listed on the enrollment/change form. The insured should select the "Secondary" checkbox next to each secondary beneficiary named.

Spousal/Registered Domestic Partner Consent

Voya Financial Employee Benefits does not require spousal/registered domestic partner consent for a beneficiary designation. This includes enrollment/change forms, and beneficiary designation forms for all states.

If the insured resides in a community property state and changes the beneficiary from the spouse/ registered domestic partner to another person or entity, then it is suggested in these situations that spousal/ registered domestic partner consent be obtained. However, Voya Financial Employee Benefits will not refuse a beneficiary designation that doesn't show spousal/registered domestic partner consent.

The community property states are Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.

Change of Beneficiary

If an insured wants to change his/her beneficiary(ies), follow these steps:

1. The insured completes a *Beneficiary Designation* form. The form must be completed, dated and signed. For each individual named as a beneficiary, the following information should be included: full name, date of birth, Social Security Number, relationship to insured, address, and phone number.
   Note: Refer to the backside of the *Beneficiary Designation* form for suggested beneficiary designation examples.

2. The employer should process the form as follows:
   a) Verify that the form has been completed properly. *(see appendix for sample form)*
   b) Verify the beneficiary is a standard designation (**refer to paragraph titled Non-Standard Designations**).

3. The employer should attach the original beneficiary form to the employee's enrollment form and provide the insured with a photocopy.

Non-Standard Designations
The *Request for Change of Beneficiary* form **must** be sent to Voya Financial Employee Benefits for approval in the following situations:

- The wording used in the request differs from the examples given on the reverse side of the *Request for Change of Beneficiary* form.
- The certificate has been assigned. *See Assignment section on page 31.*
- The previous beneficiary is irrevocable. An irrevocable beneficiary would typically be used when a divorce occurs where a life insurance benefit is awarded as part of the divorce decree. An irrevocable beneficiary could be changed if the beneficiary dies, at which time we would request proof of death, or if the irrevocable beneficiary agrees to the change.
- The employee is on Waiver of Premium claim.

Submitting a request for Change of Beneficiary form for Approval (for Non-Standard Designations only)

1. Give the insured a *Beneficiary Designation* form. Request that the form be completed, dated and signed.
2. Send the form to Voya Financial
3. Employee Benefits for approval.
4. Send copies of all enrollment/change forms, signed letters, previous absolute assignments, and beneficiary changes to the policy.
5. **Send all required documents to:**

   Voya Financial

   Employee Benefits

   Customer Service Route 6971

   PO Box 20

   Minneapolis, MN 55440-0020

6. When approved, the form will be returned to the employer. The employer should attach the original beneficiary form to the employee's enrollment form and provide the insured with a photocopy.

Exception: If coverage is assigned, the assignee receives the original.

If you have any questions, call the Customer Service Representatives at Voya Financial Employee Benefits (1-866-689-6990) listed in the Quick Plan reference section of this manual.

Assignment

An assignment is the legal transfer of all of one person's interest in a life insurance policy to another person. The original policy owner transfers (assigns) his or her right to any benefits from a policy to another person (the assignee).

Absolute assignments, which transfer ownership of a life insurance policy, are the only type of assignment allowed for group life policies.

Collateral assignments, which are used to secure a loan, are <u>not</u> allowed.

IMPORTANT

- Once an assignment has been made, only the assignee can make beneficiary changes, assignments or apply for conversion. Both the insured and assignee must sign any re-enrollment forms.
- If the assignee dies before the insured, please contact Voya Financial Employee Benefits Customer Service for instructions (1-866-689-6990).
- The assignment does not change or revoke the beneficiary currently in effect. The assignee may change the beneficiary by completing a *Beneficiary Designation* form. If an irrevocable beneficiary is named, both the assignee and beneficiary must sign the *Beneficiary Designation* form.
- The assignment cannot be released, but a new assignment can be made by the current assignee.
- Assignments will be accepted only as provided in the group policy.

Assignment cont.

How to process an Absolute Assignment

Follow these steps when processing the *Absolute Assignment of Group Life Insurance* form:

1. Have the Absolute Assignment form completed, dated and signed by the insured and the assignee.

2. Mail the Absolute Assignment form to Voya Financial Employee Benefits for approval. Include copies of all enrollment /change forms, signed letters, previous absolute assignments and beneficiary changes related to the policy.

3. **Send all required documents to:**

   Voya Financial Employee Benefits
   Customer Service Route 6971
   PO Box 20
   Minneapolis, MN 55440-0020

4. When approved, Voya Financial Employee Benefits will return the approved Absolute Assignment form to the employer. **The employer should make a photocopy for their records and forward the original Absolute Assignment form to the assignee.**

Important: In the event of filing a claim, a copy of the Absolute Assignment form must be submitted to Voya Financial Life Claims. Refer to the Quick Plan Reference section of this manual.

If you have questions, call the Customer Service Representatives at Voya Financial Employee Benefits (1-866-689-6990) listed in the Quick Plan Reference section of this manual.

Portability Choice

The portability option allows participating employees to keep their basic and/or supplemental life coverage (up to a maximum amount outlined in the certificate, if any) if the participating employee leaves his/her employer, reduces hours at work, or retires. The employee's application for portability is subject to approval by the insurance company.

Portability Life coverage may also include the employee's Dependent Life coverage, if any (up to age 70 and up to the maximum amount outlined in the certificate). Employee must apply and be approved for portability life in order for the dependents to apply and be approved. The contract provisions will remain the same with the exception of premium rates. Life Insurance coverage will terminate when the employee attains age 70.

AD&D coverage is not eligible for portability.

Employees must apply for portability no later than 31 days after employment termination (60 days for persons retiring), reduction in work hours, or retirement and before age 69. Coverage not eligible for portability may be converted or all coverage may be converted if the employee does not elect portability or is declined for portability. See page 35 for information on life conversions. *(If the termination is due to retirement, the employee may also be eligible for Retiree Life Insurance.)*

In the event the employer terminates the basic life plan with portability and/or the supplemental life plan with portability, the following conditions apply to the insureds under the terminated plan.

1. If the employer replaces our life plan with another term life plan, the life coverage for active insureds will terminate and they will not be given the option of portability coverage.

2. If the employer does not replace our life plan with another term life plan, active insureds will be given the option for portability life coverage via direct payment to the insurance company, subject to approval of their application.

3. Coverage will continue for insureds who were previously approved for portability, provided that all premiums are paid.

In the event a terminated employee is rehired and had previously ported coverage:

1. The employee must disclose the previously ported coverage upon rehire. If the previously ported coverage is not disclosed and application for additional coverage as an employee is submitted, the coverage amount would be decreased at the time of claim.
2. The re-hired employee would have the option to port their coverage a second time when they terminate; assuming they do not have any undisclosed ported coverage from previous employment.

If you have questions about terminating your plan, call your Account Executive listed in the Quick Plan Reference section of this manual.

Portability Choice cont.

Procedure to Apply for Portability

1. **The employer completes and signs the employer section of the Group Life Portability Application**. *(see appendix for sample form)* The form is available on the PersPay website, www.hca.wa.gov/perspay.

2. Send the form to the employee. Include copies of original enrollment form(s), (documenting increases and decreases in coverage), and all documents attached to the enrollment form, i.e. absolute assignment, beneficiary change.

3. The employee completes the remainder of the form and mails it to Voya Financial Employee Benefits per mailing instructions on the form. The copy of the enrollment form(s) and attached documents must be included.

4. If an applicant answers unfavorably to any of the health questions, coverage will be declined. If a question is not answered, it will be considered an unfavorable answer and coverage will be declined. The employee can revise the form and resubmit the application within the initial 31 days.

5. If the application is declined, the insurance company will notify the employee and send conversion information.

If approved, the insured will be directly billed at home on a quarterly basis for premium due. **A billing charge of $3.50 will be added to each quarterly bill.**

If you have questions about the process of portability coverage, you may contact your Account Executive listed in the Quick Plan Reference section of this manual or call our Customer Service Department at 1-800-955-7736.

Life Conversion

Our group life policies contain a conversion privilege which permits covered employees, covered spouses/registered domestic partners and eligible dependents to convert his/her life coverage to an individual policy. The conversion must be applied for no later than 31 days after the employee has terminated or been denied portability. Persons retiring and their dependents are allowed 60 days for conversion. A conversion is made without evidence of insurability. *(If the termination is due to retirement, the employee may also be eligible for Retiree Life Insurance.)*

Please refer to the *Life Conversion Information Request Form* and the *Certificate of Coverage* (booklet) for further details about the conversion privilege. Both are available on the PersPay (www.hca.wa.gov/perspay) and PEBB (www.hca.wa.gov/public-employee-benefits) websites.

Note: If the employee or his/her insured dependents have been insured for less than five years on the date of discontinuance of the Group Policy, the employee or insured dependent will not be entitled to an individual policy of Life Insurance under the Conversion of Life Insurance provision.

Follow this procedure to process a life conversion:

1. Complete the **top portion** of the *Life Conversion Information Request Form (see appendix for sample form).* Give to the employee or eligible dependent upon loss of coverage.

   - Life Conversion Information Request Form
   - Premium Rates for Whole Life Conversion Policies (page 2 of the form)
   - Conversion of Your Group Life Insurance Coverage brochure

   Make a photocopy of the *Life Conversion Information Request Form* to be retained in your files.

2. The previously covered participant is responsible for completing the **bottom portion** of the form and mailing it to Voya Financial Employee Benefits at the address indicated on the bottom of the form. The form must be received by Voya Financial Employee Benefits no later than 31 days after termination of group coverage, denial of portability, or no later than 60 days after retiring (including their dependents).

   Voya Financial Employee Benefits will send the appropriate information and application directly to the insured or eligible dependent. From this point on, the insured will deal directly with Voya Financial Employee Benefits.

If you have questions, call the Customer Service Representative at Voya Financial Employee Benefits (1-866-689-6990) listed in the Quick Plan Reference section of this manual.

Claims

Voya Financial Employee Benefits strives for the prompt payment of all insurance benefits. To assist us in the timely processing of claim payments, we greatly appreciate your cooperation in making sure all claim forms are completed properly before mailing to Voya Financial Employee Benefits. Incomplete and unassigned forms will delay processing.

Payments are mailed directly to the beneficiary, insured, or legal representative with an Explanation of Benefits. The employer will receive a copy of the Explanation of Benefits showing the date and amount of payment.

If you have questions, call the Customer Service Representative at Voya Financial Employee Benefits (1-866-689-6990) listed in the Quick Plan Reference section of this manual.

Voya Financial Personal Transition Account

If the total amount payable to a claimant is $5,000 or greater, a Voya Financial Personal Transition Account will generally be issued for the insurance policy funds unless another settlement option is elected. It is a secure account that earns a competitive interest rate. The funds are accessed by using drafts from a draftbook provided to the claimant.

A check, rather than the Voya Financial Personal Transition Account, is issued under the following circumstances:

- If the proceeds are less than $5,000
- If the beneficiary resides in a foreign country
- If the claim is for dismemberment
- If the beneficiary resides in a state where the Voya Financial Personal Transition Account is not available

Claim Forms

Because some states require specific wording on claim forms, the appropriate claim forms must be used. Please refer to the Voya Financial Employee Benefits website (see below) to select the correct claim form(s).

The Administrative Forms Library is also helpful with locating forms such as the Amendment to Original Application, Beneficiary Designation form, and more. Claim forms are also available in the Claims Forms Library.

Requirements to File a Death Claim

1. Employer completes Form #171880 (Death Claim for Group Life Plans); claimant completes Form # 131001 (Proof of Death – Claimant's Statement). *(see appendix for sample form)*

   Note: The date last worked and the status of the employee at the date of death are also needed to verify eligibility for benefits on dependent claims. The dependent claim section should be completed only in the case of death of a dependent.

2. Provide the beneficiary with the Supplemental Contract as included with the appropriate claim form on the Voya Financial Employee Benefits website. The Supplemental Contract is required unless the death benefit is less than $5,000 or the beneficiary resides in Alaska, Illinois, Kansas, Nevada, or North Carolina.

   Each enrollment form or *Beneficiary Designation* form supersedes the previous enrollment form or *Beneficiary Designation* form, so the named beneficiary is the person(s) that is listed on the most recent form.

   If there is no beneficiary designation, refer to the Beneficiary section of the *Life Insurance Certificate of Coverage*.

3. Have the beneficiary complete, date and sign all applicable sections of the *Death Claim* form. When completing the Beneficiary Statement section, if more are needed, print or copy additional statements and attach to the form. Under the Tax Residency Information and Taxpayer Certification (W-9) sections, if the beneficiary is not a U.S. citizen or organization, please contact Voya Financial Life Claims for more information.

4. Obtain an original certified copy of the official Certificate of Death issued by the Bureau of Vital Statistics.

5. Submit copies of **all** enrollment/change forms, signed letters, absolute assignments, and beneficiary changes related to the insured's coverage.

6. If newspaper clippings of the death are available, please send them with the required forms. A clipping can often speed claim payment since it may adequately answer questions that would otherwise require correspondence.

7. If a trust is named as the beneficiary, the *Trust Verification* form must be completed by the trustee of the trust.

8. If the beneficiary is a minor, a certified copy of the Letters of Guardianship for the minor's estate may be required under some circumstances. Payment is made to the legal guardian. If this situation arises, contact Voya Financial Life Claims. Please refer to the *Life Certificate of Coverage*, Beneficiary section.

9. If the employee did not name a beneficiary, or if the named beneficiary predeceased the employee, payment will be made in accordance with the terms of the group policy. If this situation arises, contact Voya Financial Life Claims.

Death Claim cont.

10. Send required documents to:

- Voya Financial Life Claims
  PO Box 1548
  Minneapolis, MN 55440

This includes:

Form #171880 (Death Claim for Group Life Plans);
Form # 131001 (Proof of Death – Claimant's Statement).A copy of all Life and Accidental Death and Dismemberment (AD&D) Insurance Enrollment/Change Forms
A copy of all Beneficiary Designation Forms
A copy of all Amendment to Original Application (formerly Nonsmoker Certification forms)
A copy of any Absolute Assignment
An original Certificate of Death
Any newspaper clippings regarding the death, if available
Trust Verification form completed by the trustee of the trust, if applicable
A certified copy of the Letters of Guardianship for the minor's estate, if applicable

To view frequently asked questions regarding a death claim, see the Frequently Asked Questions for Group Life Death Claims (Form #Death Form FAQ-EB) on Voya's website: https://claimscenter.voya.com/static/claimscenter/form-library/

Requirements to File an Accelerated Benefit Claim

Note: The accelerated benefit may be payable if an insured has a terminal condition and a life expectancy of no more than two years (24 months). Refer to your Life Insurance certificate for complete details.

1. Verify eligibility: the insured must have at least $10,000 of term life coverage. **The applicant must request this benefit in writing.**
2. Employers and employees use Form #121583 (Accelerated Benefit Claim); employees also use Forms #121489 (Attending Physician's Statement), 127182 (Authorization for Release of Health-Related Information), and 44539 (Disclosure Statement)
3. Complete the Employer's Statement section of the *Accelerated Benefit Claim* form. The Employer Certification section must be signed by an authorized agency representative. *(see appendix for sample form)*
4. Give the following to the insured:

   Accelerated Benefit Claim form
   Accelerated Benefit Disclosure Statement form
   Authorization for Release of Health-Related Information form
   Consumer Privacy Notice
   Attending Physician's Statement of Terminal Condition form
   Two Voya Financial Life Claims return envelopes

   Have the insured complete and sign the Insured's Statement section of the *Accelerated Benefit Claim* form, and the Tax Residency Information and Taxpayer Certification (W-9) sections, and the Authorization for *Release of Health-Related Information* form. The insured can send these forms directly to Voya Financial Life Claims.

   The *Attending Physician's Statement of Terminal Condition* form must be completed and signed by the insured's attending physician. The insured will provide a return envelope to the attending physician who will send the *Attending Physician's Statement of Terminal Condition* form directly to Voya Financial Life Claims.
5. If there is an irrevocable beneficiary or assignee on the policy, or if the insured resides in a community property state, the appropriate releases on the back of the claim form must also be completed and signed.
6. Submit copies of **all** enrollment/change forms, signed letters, absolute assignments and beneficiary changes related to the insured's coverage with a photocopy of the *Accelerated Benefit Claim* form. Send all required documents to:

   Voya Financial Life Claims
   PO Box 1548
   Minneapolis, MN 55440

This includes:

A copy of the Accelerated Benefit Claim form
A copy of all Life Insurance Enrollment/Change Forms
A copy of all signed letters regarding the insured's life insurance coverage

Accelarated Benefit Claim cont.

A copy of all beneficiary changes
A copy of all Amendment to Original Application (formerly Nonsmoker Certification forms)

Requirements to File an Accidental Dismemberment Benefit Claim

Note: This dismemberment benefit may be payable to an insured who suffers a covered loss as the result of an accidental injury. For a complete listing of the conditions that constitute dismemberment, see the Life Insurance certificate.

1. Verify the insured has the AD&D benefit on his/her coverage and request any accident reports that are available.

2. Employers use Form #171881 (Accidental Dismemberment Claim – Employer); employees use Forms #171882 (Accidental Dismemberment Claim – Employee), 116150 (Attending Physician's Statement of Dismemberment), and 127182 (Authorization of Release of Health-Related Information)Give the following to the insured:

   Accidental Dismemberment Claim form
   Authorization for Release of Health-Related Information form
   Consumer Privacy Notice
   Attending Physician's Statement of Dismemberment form
   Two Voya Financial Life Claims return envelopes

   Have the insured complete and sign the Insured's Statement section of the *Accidental Dismemberment Claim* form and the *Authorization for Release of Health-Related Information* form. The insured can send these two forms directly to Voya Financial Life Claims.

3. The *Attending Physician's Statement of Dismemberment* form must be completed and signed by the insured's attending physician. The insured will provide a return envelope to the attending physician so the physician can send the form directly to Voya Financial Life Claims.
4. Submit copies of the accident reports or newspaper clippings that are available. However, do not delay submitting the claim if this information is not available.
5. Submit copies of all enrollment/change forms, signed letters, and absolute assignments related to the insured's coverage. Send all required documents to:

   Voya Financial Life Claims
   PO Box 1548
   Minneapolis, MN 55440

This includes:

A copy of the Accidental Dismemberment Claim form
A copy of all Life Insurance Enrollment/Change Forms
A copy of all Request for Change of Beneficiary Forms
A copy of all Amendment to Original Application (formerly Nonsmoker Certification forms)
A copy of any Absolute Assignment related to the insured's coverage
A copy of any signed letters relating to the insured's life insurance coverage
A copy of any accident report or newspaper clippings that is available regarding the accident

Requirements to File a Waiver of Premium Claim

Note: The waiver of premium benefit allows the insured's life insurance to be continued without payment of premium while the insured is totally disabled. Refer to the Life Insurance Certificate of Coverage for further information and specific requirements about the disability waiver of premium benefit.

1. Verify eligibility: This plan requires that the insured must be disabled prior to age 60 and the disability must continue at least six months. Total disability for a period of at least six months is required to qualify for this benefit.

   Employers use Form #171892 (Waiver of Premium Disability Claim – Employer); employees use Forms #171891 (Waiver of Premium Disability Claim – Employee), 171893 (Attending Physician's Statement of Disability), and 127182 (Authorization for Release of Health-Related Information)Make a copy of the *Waiver of Premium Disability Claim* form and send to Voya Financial Life Claims. Give the original form to the employee to complete *(see step 3)*.

2. Give the following to the insured:

   Waiver of Premium Disability Claim form
   Authorization for Release of Health-Related Information form
   Consumer Privacy Notice
   Attending Physician's Statement of Disability form
   Two Voya Financial Life Claims return envelopes

   Have the insured complete and sign the Insured's Statement section of the *Waiver of Premium Disability Claim* form and the *Authorization for Release of Health-Related Information* form and send directly to Voya Financial Life Claims.

   Waiver of Life Insurance Premium Claim Packets may be requested from the HCA Warehouse on-line at: www.hca.wa.gov/perspay.

   These forms are included in the *Waiver of Life Insurance Premium Claim Packet*.

3. The *Attending Physician's Statement of Disability* form must be completed and signed by the insured's attending physician. The insured will provide a return envelope to the attending physician so the physician can send the form directly to Voya Financial Life Claims.
4. Submit copies of **all** enrollment/change forms, signed letters, absolute assignments, and beneficiary changes related to the insured's coverage. Send all required documents to:

   Voya Financial Life Claims
   PO Box 1548
   Minneapolis, MN 55440

This includes:
A copy of the Waiver of Premium Disability Claim form
A copy of all Life Insurance Enrollment/Change Forms
A copy of all Request for Change of Beneficiary Forms
A copy of all Amendment to Original Application (formerly Nonsmoker Certification forms)
A copy of any Absolute Assignment
A copy of any signed letter relating to the insured's life insurance coverage

Waiver of Premium Claim cont.

6. Voya Financial Employee Benefits will notify you in writing of the approved effective date for the waiver of premium claim.

   State agencies – Key the premium waiver in the insurance system.

   Higher education institutions – Key the premium waiver in your payroll system.

   Employer groups –

   (a) Who key in the insurance system – Key the premium waiver in the insurance system and adjust the premiums in your payroll system.

   (b) Who don't key in the insurance system – Send a copy of the forms to HCA for keying in the insurance system and adjust the premiums in your payroll system.

Termination of Coverage

Refer to the *Life Insurance Certificate of Coverage* for information about when the employee and dependent coverage ends. If the insured's Waiver of Life Insurance Premium Claim is approved, you need to terminate the insured's AD&D coverage, if any, on the Life Coverage screen effective the last day of the month in which the insurance company approved the Waiver of Life Insurance Premium Claim.

If the employee or his/her insured dependent dies within the 31/60 day period (that is available to them for life conversion), the insurance company will pay, whether or not the insured or insured dependent made application for an individual policy, the maximum amount of life insurance for which an individual policy could be issued.

Frequently Asked Questions for Waiver of Premium Claims

1. **Why should a Waiver of Premium claim be submitted?**

   The Waiver of Life Insurance Premium Disability Benefit provides that the life insurance will be continued without payment of premium as long as the insured remains totally disabled as provided by the policy, up to the benefit's termination age, if any. This benefit provides valuable life insurance protection to the insured while he or she is totally disabled.

2. **When should a Waiver of Premium claim be submitted?**

   A claim should be submitted when you believe an insured may be totally disabled as provided by the policy. The claim must be submitted within 12 months of the date of the insured's disability. You may not want to submit a claim if you know the insured will return to work within a short period of time or already has returned to work. If the insured has any coverages that are contributory and the insured is asking to file a claim, always allow them to do so.

FAQs for Premium Life Waiver cont.

3. **What is the definition of total disability?**

   The definition of total disability under the PEBB Plan can be found in the certificate of coverage. Total disability – Complete inability, because of sickness or accidental injury, to work at any occupation suited to your education, training, or experience.

4. **Are there certain eligibility requirements that an insured must meet in order to be eligible for Waiver of Premium?**

   The PEBB plan requires the disability must begin prior to age 60 and while the person is insured for the benefit.

5. **Why does Voya Financial Employee Benefits (Voya Financial EB) need enrollment information submitted with a Waiver of Premium claim?**

   Enrollment information is always needed if the employee has any coverages that are contributory. This usually includes any Supplemental Life coverage. Voya Financial EB needs to determine if proof of good health was required at the time any contributory coverage was elected.

6. **How do I know if I am including the correct enrollment information?**

   The initial and any subsequent enrollment forms for contributory coverage needs to be included with the claim submission. The enrollment forms must include the amounts of coverage and effective dates. This documentation may be paper enrollment forms or a screen print from a Human Resource administrative system that shows when coverages were initially elected. Beneficiary documentation is also required for our files.

7. **If the insured is approved for Waiver of Premium what happens to any dependent coverage or accidental death coverage the insured may have had?**

   The PEBB plan allows dependent premiums to be waived if the employee is approved for waiver. Dependent Children's coverage will terminate as defined by the plan.

8. **How will I know when a Waiver of Premium claim is approved or denied?**

   Voya Financial EB will send you a copy of our final determination letter. If the claim is approved, any adjustments to your premium statement should be made the next time you send premium to us. Premiums must continue to be paid while the claim is pending.

9. **If the insured's claim is denied, can they appeal?**

   Yes, any appeal must be submitted to us in writing within 60 days of the date of our final determination. The appeal should include the reason for the appeal and include supporting documentation for the appeal. We will respond to the appeal within 60 days of receiving the appeal.

10. **How long does the Waiver of Premium continue?**

    Employee Basic coverage reduces as defined by the plan. Employee Supplemental continues as long as the employee meets the definition of disability and conforms to the requirements as dictated by the plan.

Glossary

Approved	Individual has been underwritten by Medical Underwriting; coverage can become effective, payroll deduction begun, and certificate may be distributed.
Assignee	The person to whom rights or interest of a policy are transferred.
Assignment	The legal transfer of all of one person's interest in a policy to another.
Assignor	The person who transfers the legal rights of his or her coverage.
Beneficiary	The person to whom the proceeds of a life insurance policy are payable at the death of the insured.
Blood Profile	Individual's blood drawn by a qualified technician and sent to a designated laboratory to be analyzed for blood chemistries regarding diabetes, kidney and liver, hyperlipidemia and HIV.
Certificate	The certificate booklet that the insurance company prepares doe an individual insured under a master group policy.
Change of Action	The underwriting department indicates this on the final action notice (FAN) if there is a change or revision made to the original approval of an applicant's coverage – i.e., amount of coverage applied for is adjusted or a file is re-opened when requirements have been after the file was initially closed.
Claim	A demand presented, usually by the beneficiary, for payment of benefits under an insurance policy.
Claim Form	A claim form is submitted to the Claim Department after coverage is effective (not to be confused with the EOI Form) to collect benefits when a covered loss occurs.
Closed-Out	The underwriting process is stopped and coverage does not become effective, Common reasons for a Medical Underwriting file to be closed out: 1. Underwriting requirements for an individual have not been received by Medical Underwriting; coverage is not effective. 2. Request for coverage is withdrawn; the employee terminated; the plan canceled – coverage is not effective. 3. Individual did not need to be underwritten; EOI was submitted in error – coverage is already effective.
Conversion	The exchange of a term life insurance contract for a whole life or endowment contract in accordance with the terms of the policy provisions granting their right.
Declined	Individual has been underwritten by Medical Underwriting and coverage not approved; coverage is not effective.

Glossary cont.

Effective Date	The date the insured is actually covered under the insurance contract; the date following the insured's eligibility period, or the date of approval by Medical Underwriting, unless indicated otherwise in the contract.
EKG	This is a request for a resting electrocardiogram (not an exercise or stress test)
Evidence of Insurability (EOI)	This is the Evidence of Insurability Form submitted to Medical Underwriting to provide proof of good health (not to be confused with a claim form or an enrollment form).
ERISA	Employee retirement Income Security Act (1974) – Federal legislation establishing a comprehensive set of laws pertaining to employee benefit plans.
Examination	Individual must have a physical exam to obtain coverage. This "insurance physical" is done by a designated paramedical company and is done at the insurance company's expense.
FAN	Final Action Notice. Sent out by Voya Financial Employee Benefits Medical Underwriting Department to indicate status of an application for coverage: approved, declined, or closed.
Guaranteed Issue	Coverage issued without the applicant answering health related questions or undergoing a physical exam. Not available in all plans.
Medical Records	This is a request for the individual's medical records from his/her medical provider. An advance notice is sent to the individual. However, the individual does not need to do anything regarding this request for records. A designated company will obtain these medical records for Medical Underwriting at the insurance company's expense.
Portability	The employee's option to continue after the employee leaves the employer.
Proceeds	The amount of money payable under a policy at the death of an insured.
Questionnaire	This is a request from Voya Financial Employee Benefits Medical Underwriting Department for additional information to be answered by the individual applicant. A questionnaire is not a request for medical records and should not be completed by the individual applicant's physician.
Rider	A special policy provision which may be added to a policy to expand or limit the benefits otherwise payable.
SPD	Summary Plan Description – A small booklet with brief information about the plan and its administration. The group's employees received the SPD with other plan materials.

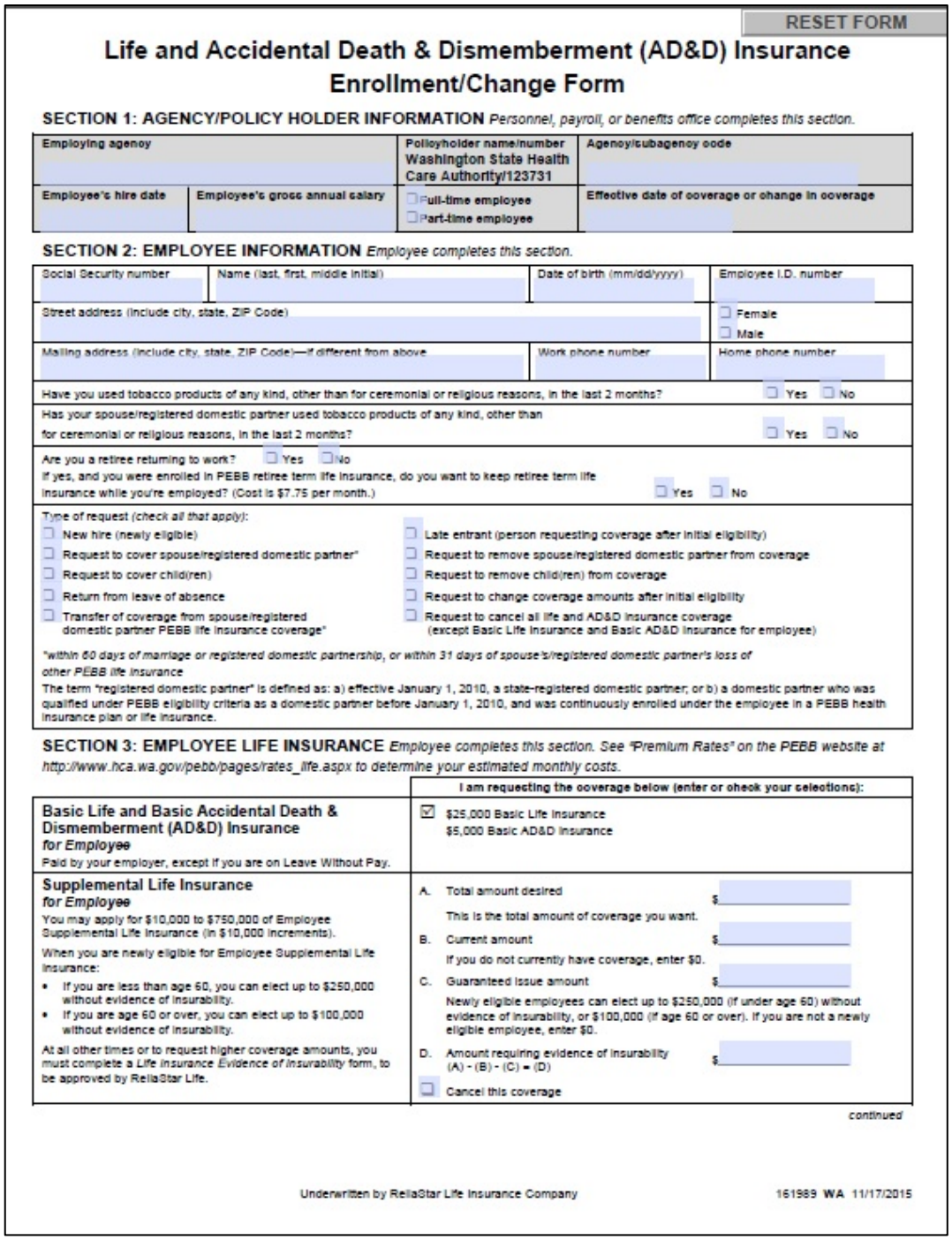
Glossary cont.

Specimen	This is a request for a urine specimen, which must be sent to a designated laboratory for analysis. A special specimen kit must be used for this urinalysis, and the analysis is done at the insurance company's expense.
Term Insurance	Life Insurance under which the benefit is payable only if the insured dies during a specified period of time or term, nothing being payable if insured survives to the end of the term.
Waiting Period	The period of time that controls the date that waiver of premium benefits begin after the insured is disabled.

Appendix

The appendix contains examples of completed forms. The forms are intended to be for reference purposes only.

Life Insurance Enrollment/Change Form



RESET FORM

Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form

SECTION 1: AGENCY/POLICY HOLDER INFORMATION *Personnel, payroll, or benefits office completes this section.*

Employing agency		Policyholder name/number Washington State Health Care Authority/123731	Agency/subagency code
Employee's hire date	Employee's gross annual salary	☐ Full-time employee ☐ Part-time employee	Effective date of coverage or change in coverage

SECTION 2: EMPLOYEE INFORMATION *Employee completes this section.*

Social Security number	Name (last, first, middle initial)	Date of birth (mm/dd/yyyy)	Employee I.D. number
Street address (include city, state, ZIP Code)			☐ Female ☐ Male
Mailing address (include city, state, ZIP Code)—if different from above		Work phone number	Home phone number

Have you used tobacco products of any kind, other than for ceremonial or religious reasons, in the last 2 months? ☐ Yes ☐ No

Has your spouse/registered domestic partner used tobacco products of any kind, other than for ceremonial or religious reasons, in the last 2 months? ☐ Yes ☐ No

Are you a retiree returning to work? ☐ Yes ☐ No

If yes, and you were enrolled in PEBB retiree term life insurance, do you want to keep retiree term life insurance while you're employed? (Cost is $7.75 per month.) ☐ Yes ☐ No

Type of request *(check all that apply)*:

- ☐ New hire (newly eligible)
- ☐ Request to cover spouse/registered domestic partner*
- ☐ Request to cover child(ren)
- ☐ Return from leave of absence
- ☐ Transfer of coverage from spouse/registered domestic partner PEBB life insurance coverage*
- ☐ Late entrant (person requesting coverage after initial eligibility)
- ☐ Request to remove spouse/registered domestic partner from coverage
- ☐ Request to remove child(ren) from coverage
- ☐ Request to change coverage amounts after initial eligibility
- ☐ Request to cancel all life and AD&D insurance coverage (except Basic Life Insurance and Basic AD&D Insurance for employee)

**within 60 days of marriage or registered domestic partnership, or within 31 days of spouse's/registered domestic partner's loss of other PEBB life insurance*

The term "registered domestic partner" is defined as: a) effective January 1, 2010, a state-registered domestic partner; or b) a domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the employee in a PEBB health insurance plan or life insurance.

SECTION 3: EMPLOYEE LIFE INSURANCE *Employee completes this section. See "Premium Rates" on the PEBB website at http://www.hca.wa.gov/pebb/pages/rates_life.aspx to determine your estimated monthly costs.*

	I am requesting the coverage below (enter or check your selections):
Basic Life and Basic Accidental Death & Dismemberment (AD&D) Insurance *for Employee* Paid by your employer, except if you are on Leave Without Pay.	☑ $25,000 Basic Life Insurance $5,000 Basic AD&D Insurance
Supplemental Life Insurance *for Employee* You may apply for $10,000 to $750,000 of Employee Supplemental Life Insurance (in $10,000 increments). When you are newly eligible for Employee Supplemental Life Insurance: • If you are less than age 60, you can elect up to $250,000 without evidence of insurability. • If you are age 60 or over, you can elect up to $100,000 without evidence of insurability. At all other times or to request higher coverage amounts, you must complete a *Life Insurance Evidence of Insurability* form, to be approved by ReliaStar Life.	A. Total amount desired $_____ This is the total amount of coverage you want. B. Current amount $_____ If you do not currently have coverage, enter $0. C. Guaranteed issue amount $_____ Newly eligible employees can elect up to $250,000 (if under age 60) without evidence of insurability, or $100,000 (if age 60 or over). If you are not a newly eligible employee, enter $0. D. Amount requiring evidence of insurability (A) - (B) - (C) = (D) $_____ ☐ Cancel this coverage

continued

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SECTION 4: SPOUSE/REGISTERED DOMESTIC PARTNER/DEPENDENT LIFE INSURANCE

Employee completes this section (only needed if you are enrolling your dependent(s) in basic and/or supplemental life insurance).

Spouse name (last, first, middle initial)	Spouse date of birth (mm/dd/yyyy)	Spouse Social Security number	Date of marriage/registration of partnership

	I am requesting the coverage below (enter or check your selections):
Basic Life Insurance *for Spouse/Registered Domestic Partner and Children* You must have Employee Supplemental Life Insurance and Basic Life Insurance for your spouse/registered domestic partner to apply for Supplemental Life Insurance for your spouse/registered domestic partner.	☐ Apply for coverage for my spouse/registered domestic partner–$2,500 life insurance ☐ Keep coverage for my spouse/registered domestic partner–$2,500 life insurance ☐ Apply for coverage for my children–$2,500 life insurance per child ☐ Keep coverage for my children–$2,500 life insurance per child ☐ Cancel spouse/registered domestic partner's coverage ☐ Cancel children's coverage
Supplemental Life Insurance *for Spouse/Registered Domestic Partner* If you have Employee Supplemental Life Insurance and Basic Life Insurance for your spouse/registered domestic partner, you may apply for Supplemental Life Insurance for your eligible spouse/registered domestic partner. You may apply for up to 50% of the amount of your Employee Supplemental Life Insurance, in $5,000 increments. When you or your spouse/registered domestic partner is newly eligible for Supplemental Life Insurance, you can elect up to $50,000 without evidence of insurability. At all other times or to request higher coverage amounts, you must complete a *Life Insurance Evidence of Insurability* form for your spouse/registered domestic partner, to be approved by RellaStar Life.	**You must have Employee Supplemental Life Insurance and Spouse/Registered Domestic Partner Basic Life Insurance to apply for Spouse/Registered Domestic Partner Supplemental Life Insurance.** A. Total amount desired $_____ This is the total amount of coverage you want. This coverage cannot exceed 50% of the Employee Supplemental Life Insurance amount. B. Current amount $_____ If you do not currently have coverage, enter $0. C. Guaranteed issue amount $_____ Newly eligible employees or newly eligible spouses/registered domestic partners can elect up to $50,000 (not to exceed 50% of the Employee Supplemental Life Insurance amount) without evidence of insurability. If you are not a newly eligible employee or spouse/ registered domestic partner, enter $0. D. Amount requiring evidence of insurability (A) - (B) - (C) = (D) $_____ ☐ Cancel this coverage

SECTION 5: SUPPLEMENTAL AD&D INSURANCE *Employee completes this section.*

	I am requesting the coverage below (check your selections):
Supplemental Accidental Death & Dismemberment (AD&D) Insurance *for Employee* You may apply for $25,000 to $250,000 of Employee Supplemental AD&D Insurance (in $25,000 increments).	☐ Employee Supplemental AD&D Insurance in the amount of $_____ *(in $25,000 increments, up to $250,000)* ☐ Cancel this coverage
Supplemental Accidental Death & Dismemberment (AD&D) Insurance *for Dependents* You must have Employee Supplemental AD&D Insurance to apply for Dependent Supplemental AD&D Insurance.	☐ Include this coverage for my dependents. ☐ Do not include coverage for my dependents. ☐ Cancel this coverage.

SECTION 6: BENEFICIARIES *Employee completes this section. Attach a list of other beneficiaries if needed (signed and dated).*

Name of beneficiary (last, first, middle initial)	☑ Primary	Relationship to employee	Date of birth (mm/dd/yyyy)
Address (include city, state, ZIP Code)	Benefit %	Social Security number	Phone number
Name of beneficiary (last, first, middle initial)	☐ Primary ☐ Secondary	Relationship to employee	Date of birth (mm/dd/yyyy)
Address (include city, state, ZIP Code)	Benefit %	Social Security number	Phone number

SECTION 7: SIGNATURE *Employee completes this section.*

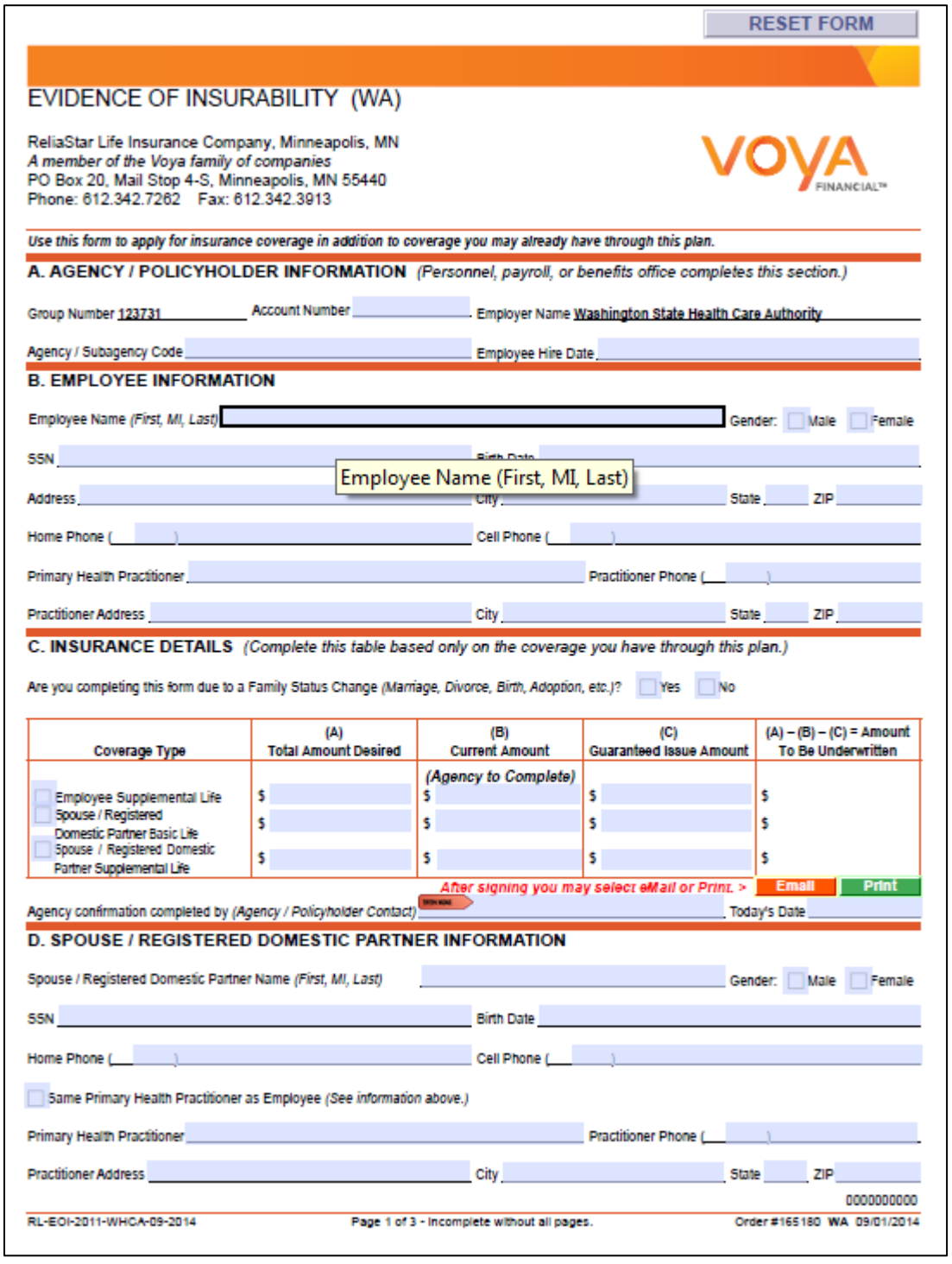
By signing this form I declare that the information I have provided is true, complete, and correct. **I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.** In addition, I understand that I and my dependents must follow eligibility and procedural criteria established by the Policyholder. I authorize my employer to deduct premiums for supplemental coverage from my paycheck. I understand that coverage begins on the effective date assigned by RellaStar Life, provided I am actively at work. I also understand that RellaStar Life may require evidence of insurability for coverage to be effective. This form replaces all previous forms and submissions I have made for PEBB life insurance. The information collected about you is confidential. We will not release any information about you without your authorization, except to conduct our business or as required or permitted by law.

Employee's signature _____ **Date** _____

Return this form to your personnel, payroll, or benefits office.

Underwritten by RellaStar Life Insurance Company 161989 WA 11/17/2015

Life Insurance Evidence of Insurability Form



RESET FORM

EVIDENCE OF INSURABILITY (WA)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya family of companies
PO Box 20, Mail Stop 4-S, Minneapolis, MN 55440
Phone: 612.342.7262 Fax: 612.342.3913

VOYA FINANCIAL™

Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

A. AGENCY / POLICYHOLDER INFORMATION *(Personnel, payroll, or benefits office completes this section.)*

Group Number 123731 Account Number _____ Employer Name Washington State Health Care Authority

Agency / Subagency Code _____ Employee Hire Date _____

B. EMPLOYEE INFORMATION

Employee Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Birth Date _____

Employee Name (First, MI, Last)

Address _____ City _____ State _____ ZIP _____

Home Phone (___) _____ Cell Phone (___) _____

Primary Health Practitioner _____ Practitioner Phone (___) _____

Practitioner Address _____ City _____ State _____ ZIP _____

C. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
		(Agency to Complete)		
☐ Employee Supplemental Life	$	$	$	$
☐ Spouse / Registered Domestic Partner Basic Life	$	$	$	$
☐ Spouse / Registered Domestic Partner Supplemental Life	$	$	$	$

After signing you may select eMail or Print. > Email Print

Agency confirmation completed by *(Agency / Policyholder Contact)* _____ Today's Date _____

D. SPOUSE / REGISTERED DOMESTIC PARTNER INFORMATION

Spouse / Registered Domestic Partner Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female

SSN _____ Birth Date _____

Home Phone (___) _____ Cell Phone (___) _____

☐ Same Primary Health Practitioner as Employee *(See information above.)*

Primary Health Practitioner _____ Practitioner Phone (___) _____

Practitioner Address _____ City _____ State _____ ZIP _____

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Employee Name _____ SSN *(Last 4 digits only.)* _____

E. EMPLOYEE AND SPOUSE / REGISTERED DOMESTIC PARTNER HEALTH QUESTIONS *(Must be answered for coverage that is not Guaranteed Issue.)*

Employee (EE) Yes	Employee (EE) No	Spouse / Domestic Partner (SP /DP) Yes	Spouse / Domestic Partner (SP /DP) No	
☐	☐	☐	☐	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having a positive HIV test or AIDS (Acquired Immunodeficiency Syndrome)?
☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/ angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP/DP. —>				3. **Employee:** Height _____ ft. _____ in. Weight _____ lbs. **Spouse/DP:** Height ___ ft. _____ in. Weight _____ lbs.
				4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
☐	☐	☐	☐	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
☐	☐	☐	☐	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	e. Polycystic kidney disease or kidney failure?
				5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory disorder?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disorder?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
☐	☐	☐	☐	e. Stomach disorder?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
☐	☐	☐	☐	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
☐	☐	☐	☐	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
☐	☐	☐	☐	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP/DP				☐ Yes ☐ No	
	☐ EE ☐ SP/DP				☐ Yes ☐ No	
	☐ EE ☐ SP/DP				☐ Yes ☐ No	
	☐ EE ☐ SP/DP				☐ Yes ☐ No	

000000000

Employee Name _____ SSN *(Last 4 digits only.)* _____

F. AUTHORIZATION AND ACKNOWLEDGMENT *(Please read and sign below)*

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations–42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.
I declare that all of the statements and answers, as they pertain to me on all pages of this Evidence Form, are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee Signature _____ Date _____

Spouse / Registered Domestic Partner Signature _____ Date _____

Submit your EOI form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: 1-612-342-3913

Or

Mail to: ReliaStar Life Insurance Company, PO Box 20, Mail Stop 4-S, Minneapolis, MN 55440

000000000

Final Action Notice (FAN) Sample

VOYA FINANCIAL™

EMPLOYEE BENEFITS
Medical Underwriting
Final Action Notice

Current Date: 09/01/2014 **Reference Number:** [redacted]

Plan Name: [redacted]
Plan Number: 123731-1
Agency [redacted]
SSN: [redacted]

[redacted]

We have received for processing the Evidence Form and taken action as indicated below. Thank you for applying for insurance coverage with our company. We appreciate the opportunity to participate in meeting your insurance needs.

FINAL ACTION:

John Doe - E

Part D*

Underwrite	$300,000	**Approve**	09/01/2014

Jane Doe - S

Part B Supplemental*

Underwrite	$172,000	**Approve**	09/01/2014

ALL LIFE INSURANCE COVERAGE IS SUBJECT TO YOUR EMPLOYER'S BENEFIT PLAN LIMITS. The amount of coverage we may approve and the amount of coverage your employer determines you are eligible for may not be the same. If your life insurance coverage is limited by your employer's benefit plan, the death benefit under your policy (including any refund of premiums) will be adjusted at the time of claim payment. Please contact your employer for specific details regarding your employer's benefit plan limits.

PLEASE NOTE THAT APPROVED LIFE INSURANCE COVERAGE MAY NOT BE EFFECTIVE IMMEDIATELY. The effective date of your coverage is determined by your employer's benefit plan and the group contract. The Company will have no liability for any claim on account of death occurring prior to the effective date of coverage. Please contact your employer for specific details regarding your coverage effective date.

An appeal regarding this underwriting determination must be in writing and be made within 90 days of the date you receive this communication. In order to give your appeal proper consideration, it should include: your name, your reference number, the specific reasons for your appeal and any additional medical evidence or documentation to support your appeal. Our written response will be sent to you within 21 days after receipt of your written appeal.

Questions regarding the underwriting process can be submitted to us in writing at P. O. Box 20, Route 7812, Minneapolis, MN 55440-9978 or call us at the number listed below. When writing or calling, be sure to give us the Reference Number indicated in the upper right section of this notice.

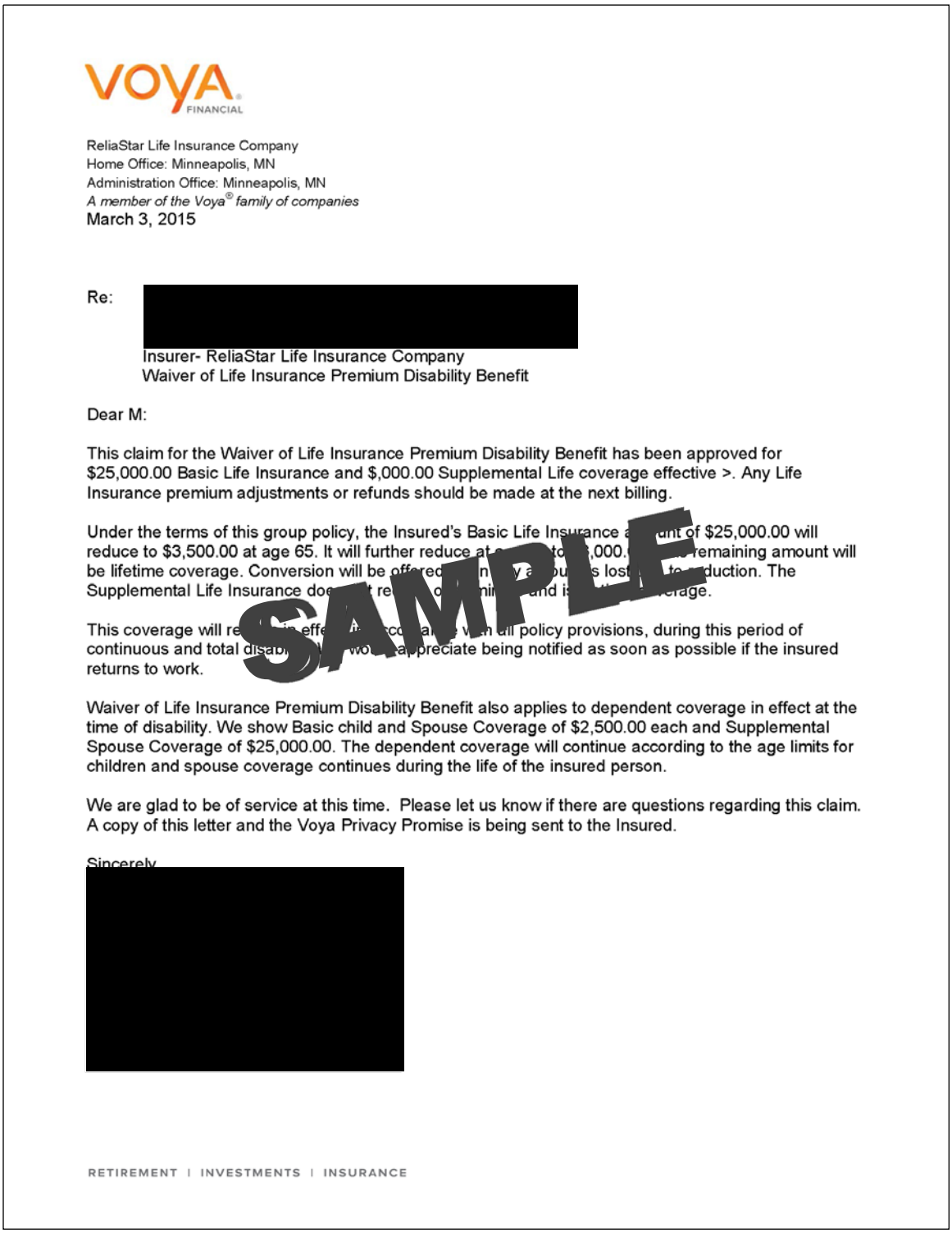
Administrative Office, Mail Stop 4-S
20 Washington Avenue South
Minneapolis, MN 55401

FAX 612-342-3913
Phone: 800-537-5024 Option 4

ReliaStar Life Insurance Company* and ReliaStar Life Insurance Company of New York are members of the Voya™ family of companies.**

Page 1 of 1

Life Insurance Waiver Letter Sample



ReliaStar Life Insurance Company
Home Office: Minneapolis, MN
Administration Office: Minneapolis, MN
A member of the Voya® family of companies
March 3, 2015

Re: [redacted]
Insurer- ReliaStar Life Insurance Company
Waiver of Life Insurance Premium Disability Benefit

Dear M:

This claim for the Waiver of Life Insurance Premium Disability Benefit has been approved for $25,000.00 Basic Life Insurance and $,000.00 Supplemental Life coverage effective >. Any Life Insurance premium adjustments or refunds should be made at the next billing.

Under the terms of this group policy, the Insured's Basic Life Insurance a[illegible]nt of $25,000.00 will reduce to $3,500.00 at age 65. It will further reduce at [illegible]to[illegible],000.[illegible] remaining amount will be lifetime coverage. Conversion will be offered [illegible]n[illegible]y a[illegible]u[illegible]s lost [illegible]to[illegible]duction. The Supplemental Life Insurance doe[illegible]t re[illegible]o[illegible]nil[illegible] and is [illegible]verage.

SAMPLE

This coverage will re[illegible]n effe[illegible]A[illegible]cc[illegible]a[illegible]e w[illegible]h all policy provisions, during this period of continuous and total disab[illegible] wo[illegible]appreciate being notified as soon as possible if the insured returns to work.

Waiver of Life Insurance Premium Disability Benefit also applies to dependent coverage in effect at the time of disability. We show Basic child and Spouse Coverage of $2,500.00 each and Supplemental Spouse Coverage of $25,000.00. The dependent coverage will continue according to the age limits for children and spouse coverage continues during the life of the insured person.

We are glad to be of service at this time. Please let us know if there are questions regarding this claim. A copy of this letter and the Voya Privacy Promise is being sent to the Insured.

Sincerely,
[redacted]

RETIREMENT | INVESTMENTS | INSURANCE

Amendment to Original Application (non-tobacco) Form

Amendment to Original Application

Please return this completed form to your personnel, payroll, insurance, or benefits office. The change in rate will be effective the first of the month following the signature date.

Name **Washington State Health Care Authority**		
Group Number 12373-1	Account Number ☐ Account 10 Higher-Education Employees ☐ Account 20 State Employees	☐ Account 30 K-12 Employees ☐ Accout 40 Political Subdivision Employees
Applicant Name - Please Print (Last, First, M.I.)		
Birth Date	Social Security Number	

For purposes of applying for the NON-TOBACCO USER RATE, I hereby amend my application for insurance to include my and/or my spouse/registered domestic partner's answer to the following questions, agreeing that this amendment is to be made a part of my application and considered as a basis of the contract for insurance.

Tobacco products
Any product made with or derived from tobacco that is intended for human consumption including any component, part, or accessory of a tobacco product. This includes, but is not limited to cigars, cigarettes, chewing tobacco, snuff, and other tobacco products. It does not included U.S. Food and Drug Administration (FDA) approved quit aids or e-cigarettes until their tobacco related status is determined by the FDA.

Tobacco use
Tobacco use is defined as any use of tobacco products within the past two months. It does not include the religious or ceremonial use of tobacco.

1. Have you used tobacco products in the last 2 months? ☐ Yes ☐ No
2. Is your spouse/registered domestic partner covered by spouse/registered domestic partner Supplemental Life Insurance? ☐ Yes ☐ No
3. If yes, has your spouse/registered domestic partner used tobacco products in the last 2 months? ☐ Yes ☐ No

The Tobacco User premium rate applies:

- To the employee if s/he has used tobacco products in the last 2 months; or
- To the employee and the spouse/registered domestic partner covered under the spouse/registered domestic partner Supplemental Life Insurance if either person has used tobacco products in the last 2 months.

Dated on this _____ day of _____, in the year, _____

_____
Signature of Employee

_____
Signature of Owner (if other than Employee)

Insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya™ family of companies

RETIREMENT | INVESTMENTS | INSURANCE

VOYA FINANCIAL™

Beneficiary Designation Change Request

RESET FORM

BENEFICIARY DESIGNATION REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya family of companies
(the "Company")
PO Box 20, Minneapolis, MN 55440

VOYA FINANCIAL™

INSURED INFORMATION

Insured Name ____ Birth Date ____ SSN ____ Phone ____

Employer/Plan Administrator Name ____ Policy Number(s) ____

BENEFICIARY INFORMATION *(See page 2 for form completion instructions.)*

I request that the beneficiaries under this policy/certificate be changed as indicated below. Unless otherwise provided in this request, if two or more primary beneficiaries are named, the proceeds shall be paid in equal shares to the named primary beneficiaries if surviving the insured. If no primary beneficiaries survive, the proceeds shall be paid in equal shares to the named contingent beneficiaries, if any. If no beneficiary survives, payment shall be made according to the terms of the policy. The right of the owner to change the beneficiary hereafter is reserved.

Primary Beneficiary: The person designated to receive insurance proceeds when they become due.

Contingent Beneficiary: (Also referred to as a secondary beneficiary.) An alternate beneficiary designated to receive insurance proceeds if there is no eligible primary beneficiary.

Spousal Consent: ReliaStar Life Insurance Company does not require spousal consent for a beneficiary designation and will not refuse a beneficiary designation based on lack of spousal consent. However, if the insured resides in a community property state and changes the beneficiary from the spouse to another person or entity, it is suggested that spousal consent be obtained to protect the claim proceeds of the named beneficiary.

For each Beneficiary give Full Name, Address (street, city, state and zip code), Phone, Birth Date, Social Security Number and Relationship to Insured.

Full Name (First, MI, Last) Address & Phone Number	Birth Date	SSN/TIN	Relationship	%	Beneficiary Type
					☐ Primary ☐ Contingent

Beneficiary Designation change is requested for:
☐ All Life and/or AD&D Insurance ☐ Basic Life and/or AD&D Insurance[1] ☐ Supplemental Life and/or AD&D Insurance[1]

Full Name (First, MI, Last) Address & Phone Number	Birth Date	SSN/TIN	Relationship	%	Beneficiary Type
					☐ Primary ☐ Contingent

Beneficiary Designation change is requested for:
☐ All Life and/or AD&D Insurance ☐ Basic Life and/or AD&D Insurance[1] ☐ Supplemental Life and/or AD&D Insurance[1]

Full Name (First, MI, Last) Address & Phone Number	Birth Date	SSN/TIN	Relationship	%	Beneficiary Type
					☐ Primary ☐ Contingent

Beneficiary Designation change is requested for:
☐ All Life and/or AD&D Insurance ☐ Basic Life and/or AD&D Insurance[1] ☐ Supplemental Life and/or AD&D Insurance[1]

[1]Note: Coverage may not be offered through your Employer/Plan Administrator.

AUTHORIZATION AND ACKNOWLEDGMENT

This designation is revocable as to each beneficiary except when otherwise stated, and beneficiaries of like class shall share equally with right of survivorship. Please refer to the Suggested Beneficiary Designations on page 2 of this form. Any designation of an individual shall mean an individual living at the insured's death.

Owner/Insured Signature ____ Date ____

Owner/Insured Address ____ City ____ State ____ ZIP ____

Irrevocable Beneficiary(ies) Signature(s) *(if any)* ____ Date ____

Spousal Consent Signature *(optional)* ____ Date ____

7384w Page 1 of 2 - Incomplete without all pages. Order #114834 09/01/2014

Group Life Portability Application

RESET FORM

Group Life Portability Application

ReliaStar Life Insurance Company
Home Office: Minneapolis, Minnesota

Employer / Administrator:
Read the certificate to determine eligibility for portability. Complete and sign the Employer/Administrator section of this form. Send this form to the employee to complete, along with copies of initial and all subsequent enrollment/application form(s), beneficiary designations, and assignments.

Employee:
Complete the Employee section and return the form to the address shown at the end of the form. Be sure to include copies of enrollment/application form(s), beneficiary designations and assignments. Coverage can not be ported without this information. The insurer must receive this completed form within 31 days (60 days if you are retiring) of the coverage termination date. If you do not want to apply for portability and only want to receive information about conversion, please refer to the section TO RECEIVE CONVERSION INFORMATION ONLY (near top of page two).

THIS SECTION TO BE COMPLETED BY EMPLOYER/ADMINISTRATOR

Employer or Group name	Group Policy number(s)	Account number	Date of hire	Annual Salary at Termination
State of Washington	12373-1	☐ Account 10 State Higher Education ☐ Account 20 State Employees ☐ Account 30 K-12 Employees ☐ Account 40 Political Subdivision Employees		

Employee name	Social Security Number	Date of birth	Date last worked	Coverage termination date

Coverage Type	Coverage Effective Date *(mm/dd/yyyy)*	Coverage Amount at Termination
Employee Basic Life Insurance		$25,000
Employee Supplemental Life Insurance		$
Dependent Spouse/Domestic Partner Basic Life Insurance		$
Dependent Spouse/Domestic Partner Supplemental Life Insurance		$
Dependent Child(ren) Basic Life Insurance		$

I certify that the above information is true and correct according to the employer's records.
Please note: Signature, name, title, agency, and telephone number must be included on the application or it will not be processed.

This form will be ☐ handed ☐ mailed to employee on _____(date)

Authorized Signature of Payroll or Benefits Office Staff	Agency phone number ( )
Print Name and Title	Agency number

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Employee billing address *(street, city, state, zip)*	Phone Number

Insured dependent spouse/Washington State-registered domestic partner name	Date of birth

Insured dependent child(ren) name(s)	Date(s) of birth

Employee continue on page 2

Employee name	Date of birth

To be eligible for portability, you must be able to answer "no" to all of the health questions below. To port dependent spouse or Washington State-registered domestic partner coverage, your spouse or Washington State-registered domestic partner must also be able to answer "no" to all of the health questions below. You must port Employee coverage in order to port coverage on your Spouse/Washington State-registered domestic partner and your children. For any Life Insurance not eligible for portability, or if portability is not approved by ReliaStar Life Insurance Company, conversion to an individual life insurance policy may be an option. Please read the Conversion Rights in your group certificate to determine eligibility for conversion. ReliaStar Life Insurance Company will send you a description of the conversion plan, premium rates, and an application form.

TO RECEIVE CONVERSION INFORMATION ONLY

If you do not want to apply for portability and only want to receive information about conversion, you can request conversion information from your personnel, payroll or benefits staff or please check the box at the right to receive conversion information from the insurance company. You may then skip the next two sections of this form. Please sign and date the form and return it as directed below.

☐ No Portability

PORTABILITY ELECTIONS

Read your group certificate carefully to determine which coverage(s) are eligible for portability. You may only elect to port coverage that is terminating on your coverage termination date. You will not be able to elect or increase ported coverage in the future. Please refer to the attached sheet for portability premium rate information.

Employee Basic and Supplemental Life Insurance	• Minimum $5,000 • Will not exceed the lesser of $750,000 or 5 times Basic Yearly Earnings	☐ 100% of terminated amount ☐ 75% of terminated amount ☐ 50% of terminated amount ☐ 25% of terminated amount
Dependent Spouse/Washington State-registered domestic partner Basic & Supplemental Life Insurance	• Same percent elected for Employee Life • Will not exceed Employee Life amount ported	☐ Elect to Port ☐ Waive
Dependent Child(ren) Basic Life Insurance	• Same percent elected for Employee Life • Will not exceed the lesser of Employee Life amount ported or $2,500	☐ Elect to Port ☐ Waive

If you elect to port less than 100% of all Life coverage(s) and you also want conversion information, you can request conversion information from your personnel, payroll or benefits staff or please check the box at the right to receive conversion information from the insurance company.

☐ Send conversion information

ANSWER THESE QUESTIONS FOR PORTABILITY	Employee	Spouse/Washington State-registered domestic partner
Are you terminating active employment due to a disability that has, or is expected to result in your inability to perform the regular duties of your occupation?	☐ Yes ☐ No	
In the past 2 years, have you been diagnosed or treated (including taking prescribed medications) by a medical professional for any of the following: cardiovascular or liver disorder, kidney or neurological disease, drug or alcohol abuse, emphysema, cancer, stroke or diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever been diagnosed or treated (including taking prescribed medications) by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No	☐ Yes ☐ No

READ THIS INFORMATION AND THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand that portability is subject to the approval of ReliaStar Life Insurance Company.
- I have received ReliaStar Life Insurance Company's Consumer Privacy Notice and Insurance Information Practices Notice.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance 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.

Signature of insured employee	Date
Signature of insured spouse/Washington State-registered domestic partner	Date

Mail this form and all other documentation within 31 days (60 days if you are retiring) of coverage termination to:

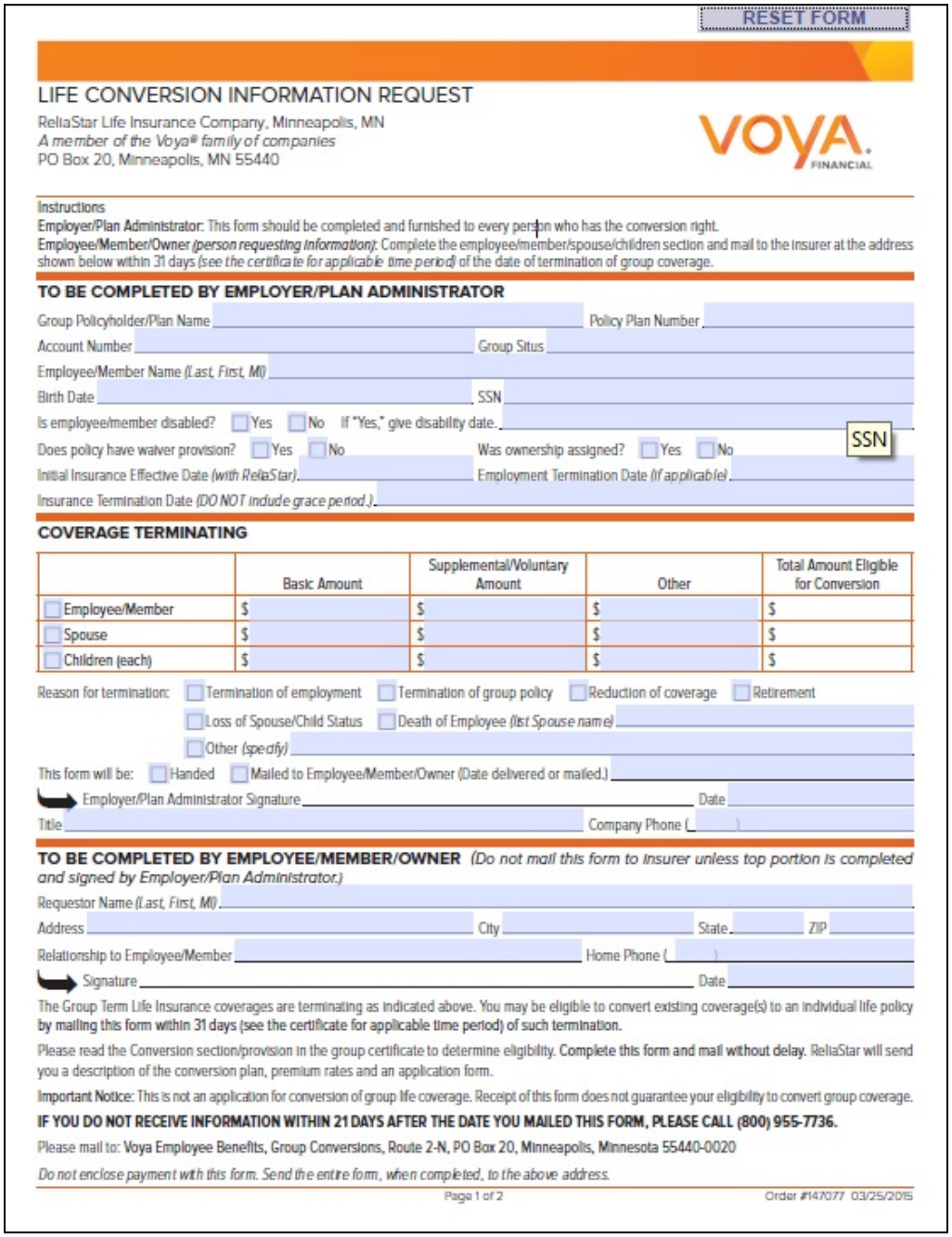
ReliaStar Life Insurance Company
Route 2N-New Business
20 Washington Avenue South
Minneapolis, MN 55401

Questions? Call Customer Service at 1-866-689-6990

GATPORT06-STF

(07/11)

Life Conversion Information Request Form



RESET FORM

LIFE CONVERSION INFORMATION REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
PO Box 20, Minneapolis, MN 55440

VOYA FINANCIAL

Instructions
Employer/Plan Administrator: This form should be completed and furnished to every person who has the conversion right.
Employee/Member/Owner ***(person requesting information):*** Complete the employee/member/spouse/children section and mail to the insurer at the address shown below within 31 days *(see the certificate for applicable time period)* of the date of termination of group coverage.

TO BE COMPLETED BY EMPLOYER/PLAN ADMINISTRATOR

Group Policyholder/Plan Name _____ Policy Plan Number _____
Account Number _____ Group Situs _____
Employee/Member Name *(Last, First, MI)* _____
Birth Date _____ SSN _____
Is employee/member disabled? ☐ Yes ☐ No If "Yes," give disability date. _____
Does policy have waiver provision? ☐ Yes ☐ No Was ownership assigned? ☐ Yes ☐ No
Initial Insurance Effective Date *(with ReliaStar)* _____ Employment Termination Date *(if applicable)* _____
Insurance Termination Date *(DO NOT include grace period.)* _____

SSN

COVERAGE TERMINATING

	Basic Amount	Supplemental/Voluntary Amount	Other	Total Amount Eligible for Conversion
☐ Employee/Member	$	$	$	$
☐ Spouse	$	$	$	$
☐ Children (each)	$	$	$	$

Reason for termination: ☐ Termination of employment ☐ Termination of group policy ☐ Reduction of coverage ☐ Retirement
☐ Loss of Spouse/Child Status ☐ Death of Employee *(list Spouse name)* _____
☐ Other *(specify)* _____
This form will be: ☐ Handed ☐ Mailed to Employee/Member/Owner (Date delivered or mailed.) _____
Employer/Plan Administrator Signature _____ Date _____
Title _____ Company Phone (___) _____

TO BE COMPLETED BY EMPLOYEE/MEMBER/OWNER *(Do not mail this form to insurer unless top portion is completed and signed by Employer/Plan Administrator.)*

Requestor Name *(Last, First, MI)* _____
Address _____ City _____ State _____ ZIP _____
Relationship to Employee/Member _____ Home Phone (___) _____
Signature _____ Date _____

The Group Term Life Insurance coverages are terminating as indicated above. You may be eligible to convert existing coverage(s) to an individual life policy by mailing this form within 31 days (see the certificate for applicable time period) of such termination.

Please read the Conversion section/provision in the group certificate to determine eligibility. **Complete this form and mail without delay.** ReliaStar will send you a description of the conversion plan, premium rates and an application form.

Important Notice: This is not an application for conversion of group life coverage. Receipt of this form does not guarantee your eligibility to convert group coverage.

IF YOU DO NOT RECEIVE INFORMATION WITHIN 21 DAYS AFTER THE DATE YOU MAILED THIS FORM, PLEASE CALL (800) 955-7736.

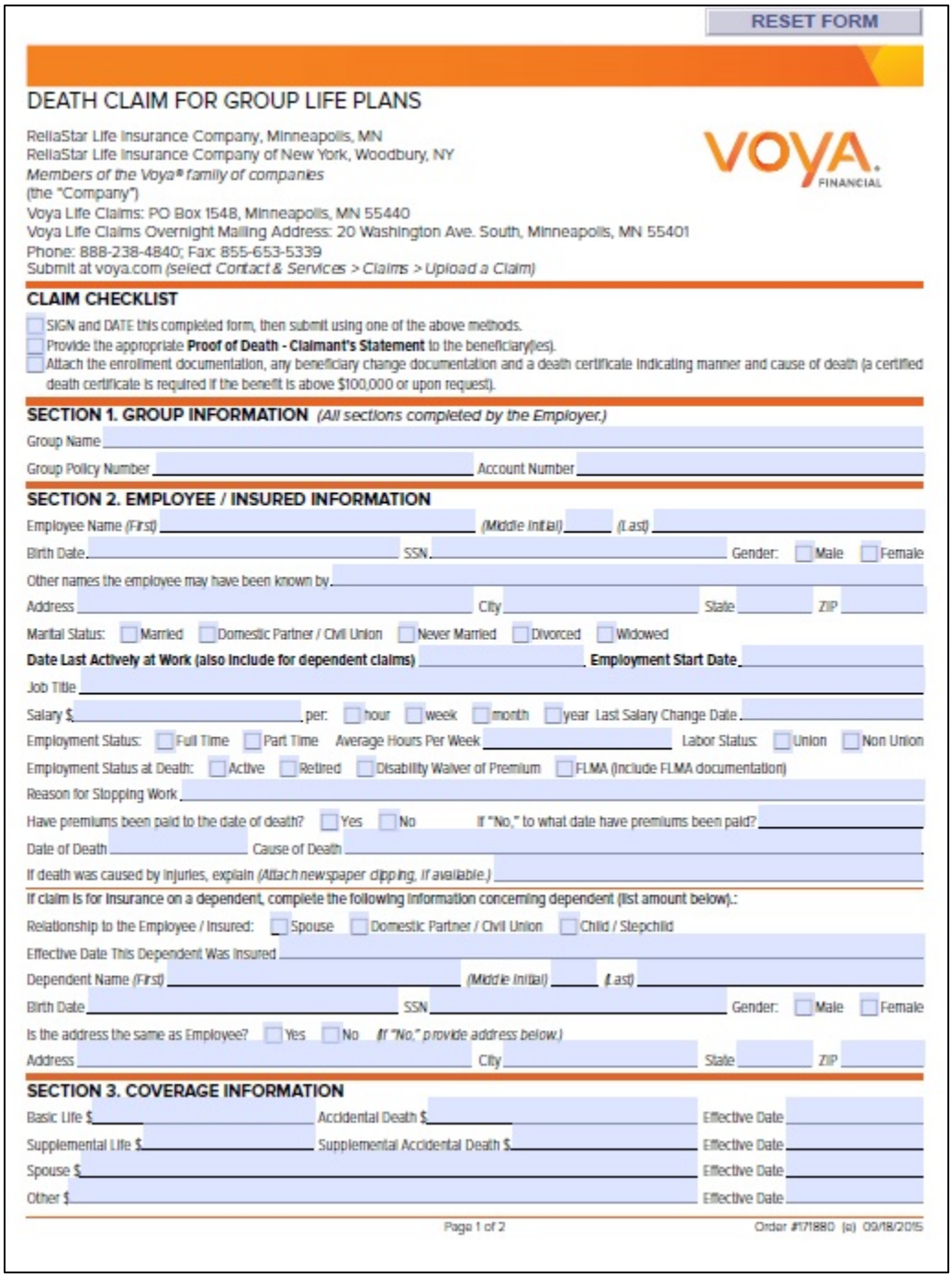
Please mail to: Voya Employee Benefits, Group Conversions, Route 2-N, PO Box 20, Minneapolis, Minnesota 55440-0020

Do not enclose payment with this form. Send the entire form, when completed, to the above address.

Page 1 of 2 Order #147077 03/25/2015

Death Claim

See the Claim section in this manual for step-by-step instructions.



RESET FORM

DEATH CLAIM FOR GROUP LIFE PLANS

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440
Voya Life Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis, MN 55401
Phone: 888-238-4840; Fax: 855-653-5339
Submit at voya.com *(select Contact & Services > Claims > Upload a Claim)*

VOYA FINANCIAL

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 (a certified death certificate is required if the benefit is above $100,000 or upon request).

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

Group Name _____
Group Policy Number _____ Account Number _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Other names the employee may have been known by _____
Address _____ City _____ State _____ ZIP _____
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 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 ☐ FLMA (Include FLMA documentation)
Reason for Stopping Work _____
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.)* _____

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 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 3. COVERAGE INFORMATION

Basic Life $_____ Accidental Death $_____ Effective Date _____
Supplemental Life $_____ Supplemental Accidental Death $_____ Effective Date _____
Spouse $_____ Effective Date _____
Other $_____ Effective Date _____

Page 1 of 2 Order #171880 (a) 09/18/2015

Employee Name _____ Group Policy Number _____

SECTION 4. EMPLOYER CERTIFICATION

The undersigned certifies that the above statements as to the Insured are correct as reported on its records. A Voya Personal Transition Account Supplemental Contract as identified on the Company web site, Voya.com/us/businesses/employeebenefits/formslibrary/deathclaims/index.htm, 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 _____ Title _____

Employer Address _____ City _____ State _____ ZIP _____

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.

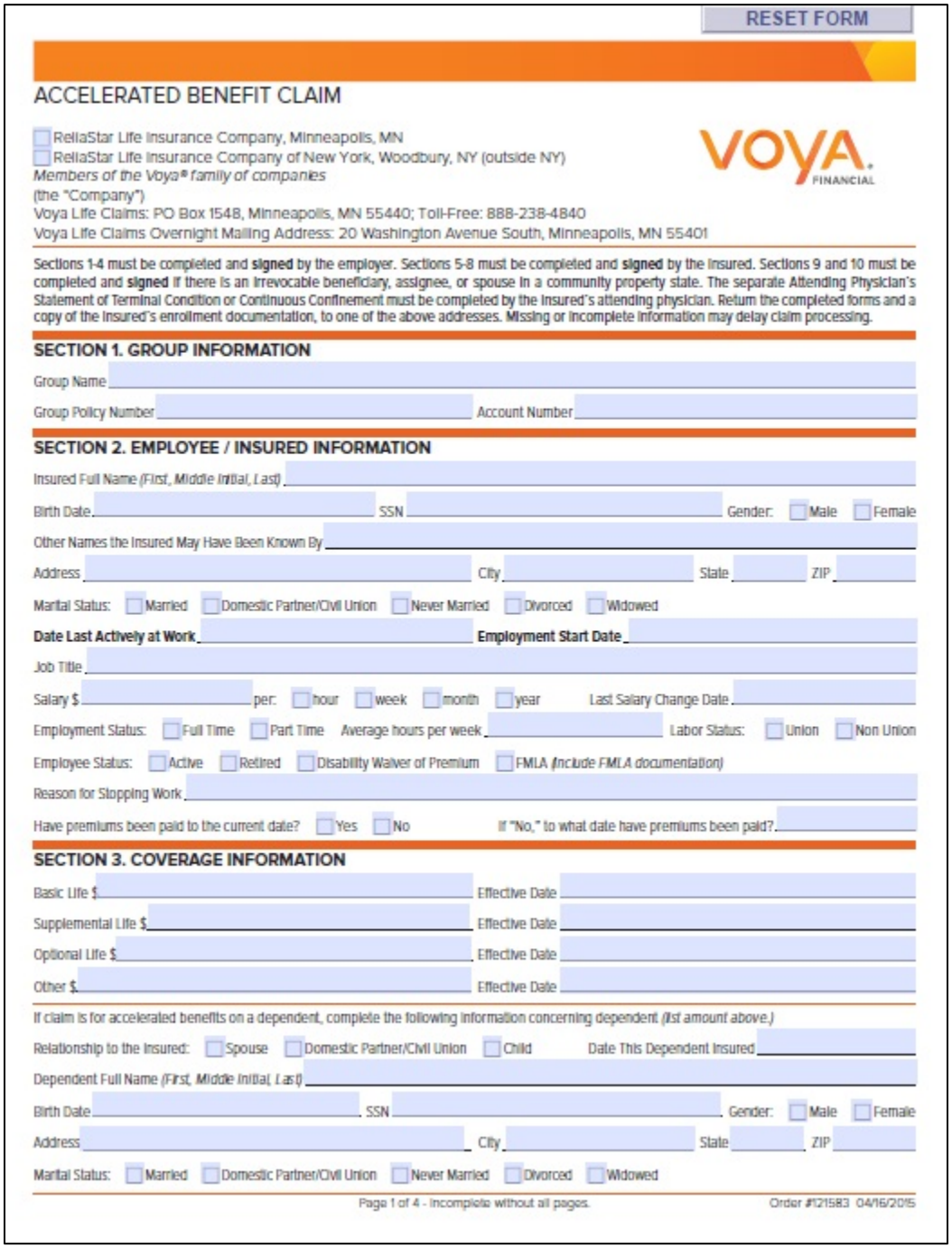
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

Accelerated Benefit Claim



RESET FORM

ACCELERATED BENEFIT CLAIM

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the Voya® family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440; Toll-Free: 888-238-4840
Voya Life Claims Overnight Mailing Address: 20 Washington Avenue South, Minneapolis, MN 55401

Sections 1-4 must be completed and **signed** by the employer. Sections 5-8 must be completed and **signed** by the insured. Sections 9 and 10 must be completed and **signed** if there is an irrevocable beneficiary, assignee, or spouse in a community property state. The separate Attending Physician's Statement of Terminal Condition or Continuous Confinement must be completed by the insured's attending physician. Return the completed forms and a copy of the insured's enrollment documentation, to one of the above addresses. Missing or incomplete information may delay claim processing.

SECTION 1. GROUP INFORMATION

Group Name _____

Group Policy Number _____ Account Number _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

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

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Other Names the Insured May Have Been Known By _____

Address _____ City _____ State _____ ZIP _____

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

Date Last Actively at Work _____ **Employment Start Date** _____

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

Employee Status: ☐ Active ☐ Retired ☐ Disability Waiver of Premium ☐ FMLA *(Include FMLA documentation)*

Reason for Stopping Work _____

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

SECTION 3. COVERAGE INFORMATION

Basic Life $ _____ Effective Date _____

Supplemental Life $ _____ Effective Date _____

Optional Life $ _____ Effective Date _____

Other $ _____ Effective Date _____

If claim is for accelerated benefits on a dependent, complete the following information concerning dependent *(list amount above.)*

Relationship to the Insured: ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child Date This Dependent Insured _____

Dependent Full Name *(First, Middle Initial, Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

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

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Insured Name _____ Group Policy Number _____

SECTION 4. EMPLOYER CERTIFICATION *(The undersigned certifies that the above statements as to the insured are correct as reported on its records. See page 4 for Fraud Warnings.)*

Employer Name _____ Title _____

Employer Address _____ City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Email _____ Phone (___) _____

SECTION 5. INSURED STATEMENT *(Please read and sign below. Please review the policy, certificate or rider to verify if continuous confinement is a qualifying event for receipt of a benefit, or if monthly payments are available to you. For group coverage, a copy of the certificate and any riders can be obtained from the Employer/Plan Sponsor. See page 4 for Fraud Warnings.)*

Date Employee Last Worked Preceding Claim *(month, day, year)* _____

Describe Condition or Illness _____

What is the qualifying event for this claim? ☐ Terminal Illness ☐ Continuous Confinement in an Institution

If qualifying event is continuous confinement in an institution, how would you like to receive your benefit? ☐ Lump sum ☐ Monthly payments

Requested whole percentage for monthly accelerated benefit (See rider for percentages available. The percentage chosen must be a minimum of $500 monthly.) _____

SECTION 6. ATTENDING PHYSICIAN(S) *(List your primary care physicians.)*

Physician Name _____ Date _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (___) _____ Fax (___) _____

Cause _____

Physician Name _____ Date _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (___) _____ Fax (___) _____

Cause _____

Physician Name _____ Date _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (___) _____ Fax (___) _____

Cause _____

SECTION 7. US 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 [1], and
3. I am a U.S. person

[1] *If you are subject to backup withholding, you must strike through statement number 2.*

NON-RESIDENT ALIEN STATUS

If you are a Non-Resident Alien, please 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 US tax treaty.

Insured Name _____ Group Policy Number _____

SECTION 8. ACKNOWLEDGEMENT AND AUTHORIZATION

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc. (MIB) or employer to give ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York ("the Company") or its agents, employees and authorized representatives acting on its behalf, ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information as they apply to me, my spouse, or any of my children who are insured. I give my permission to the Company, and its reinsurers, to make a brief report of personal health information to MIB about these same persons.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

NOTE: Receipt of accelerated benefits may be taxable. Assistance should be sought from a personal tax advisor. Receipt of these accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Receipt of these accelerated benefits may adversely affect the recipient's eligibility for future increases in life insurance coverage. Please refer to your certificate booklet for more information.

If accelerated benefits are paid, continued premium payments must be made, unless waived under the provisions of the policy, to keep life insurance coverage in force.

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

➥ Insured Signature _____ Date _____

Phone (___) _____ Email _____

SECTION 9. RELEASE

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

If there is an irrevocable beneficiary or assignee, that person must sign this section and have it notarized. If you are married and live in a community property state, your spouse must sign this section and have it notarized.

The undersigned acknowledges and consents to this accelerated benefit claim; that if approved, payment of the accelerated benefit shall be made to the insured or his/her legal representative; and in consideration of such payment the undersigned agrees that the liability of the Company under the policy shall be discharged by the amount of the accelerated benefit paid.

➥ Irrevocable Beneficiary or Assignee Signature _____ Date _____

➥ Spouse Signature *(In Community Property State)* _____ Date _____

SECTION 10. NOTARY SECTION *(required with the above release by irrevocable beneficiary or assignee or spouse)*

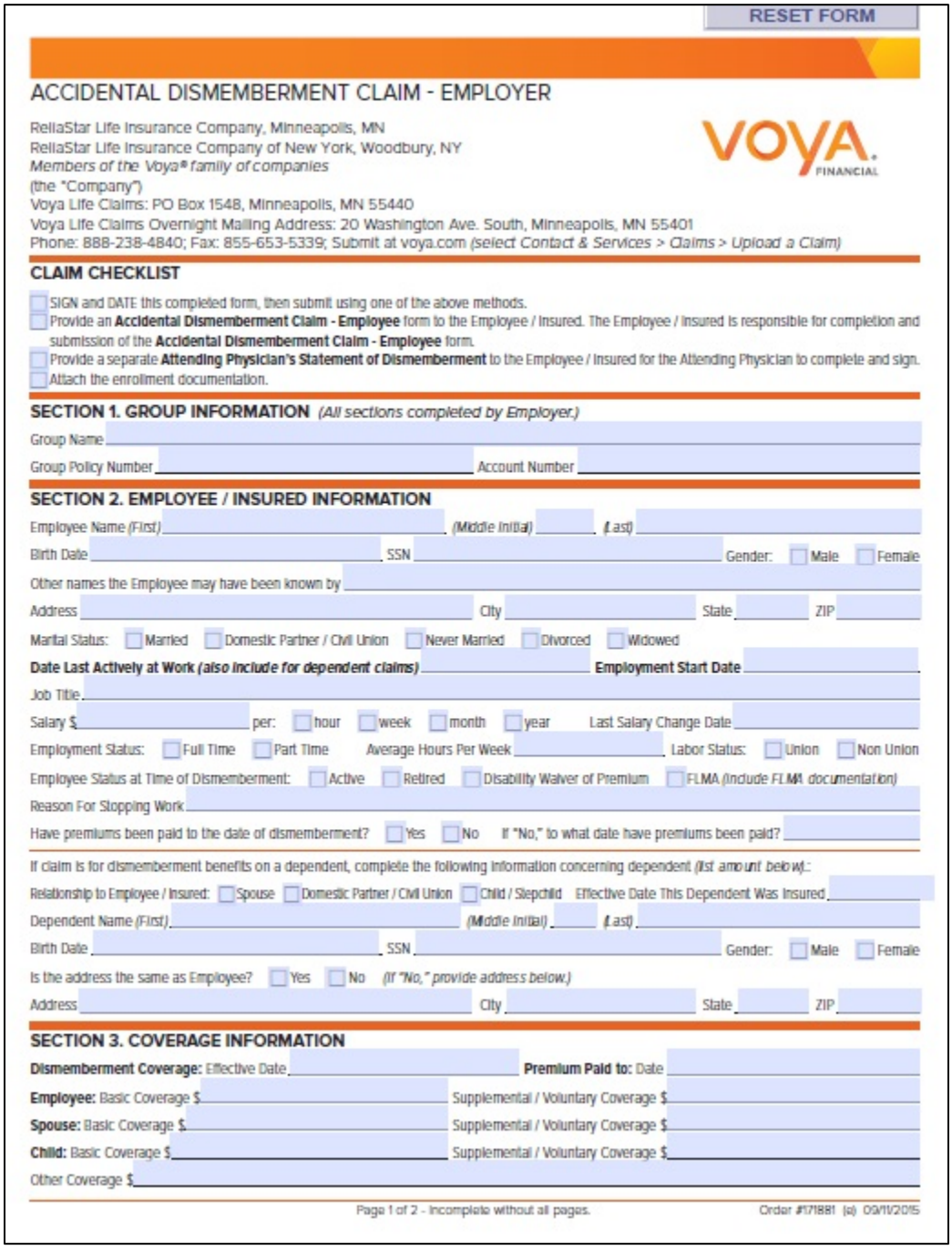
State of _____

County of _____ ss.

On this _____ day of _____, 20___ before me personally appeared _____ to me known to be the same person who executed the above instrument and acknowledged that he/she executed the same as his/her free act and deed.

My commission expires _____ Notary Public _____

Accidental Dismemberment Claim



RESET FORM

ACCIDENTAL DISMEMBERMENT CLAIM - EMPLOYER

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440
Voya Life Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis, MN 55401
Phone: 888-238-4840; Fax: 855-653-5339; Submit at voya.com *(select Contact & Services > Claims > Upload a Claim)*

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ Provide an **Accidental Dismemberment Claim - Employee** form to the Employee / Insured. The Employee / Insured is responsible for completion and submission of the **Accidental Dismemberment Claim - Employee** form.
- ☐ Provide a separate **Attending Physician's Statement of Dismemberment** to the Employee / Insured for the Attending Physician to complete and sign.
- ☐ Attach the enrollment documentation.

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

Group Name _____
Group Policy Number _____ Account Number _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Other names the Employee may have been known by _____
Address _____ City _____ State _____ ZIP _____
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 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
Employee Status at Time of Dismemberment: ☐ Active ☐ Retired ☐ Disability Waiver of Premium ☐ FLMA *(include FLMA documentation)*
Reason For Stopping Work _____
Have premiums been paid to the date of dismemberment? ☐ Yes ☐ No If "No," to what date have premiums been paid? _____

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

Relationship to Employee / Insured: ☐ Spouse ☐ Domestic Partner / Civil Union ☐ Child / Stepchild Effective Date This Dependent Was Insured _____
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 3. COVERAGE INFORMATION

Dismemberment Coverage: Effective Date _____ **Premium Paid to:** Date _____
Employee: Basic Coverage $_____ Supplemental / Voluntary Coverage $_____
Spouse: Basic Coverage $_____ Supplemental / Voluntary Coverage $_____
Child: Basic Coverage $_____ Supplemental / Voluntary Coverage $_____
Other Coverage $_____

Page 1 of 2 - Incomplete without all pages. Order #171881 (s) 09/11/2015

Employee Name _____ Group Policy Number _____

SECTION 4. 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.

Employer Name _____ Title _____

Employer Address _____ City _____ State _____ ZIP _____

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

Alaska, Alabama, 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.

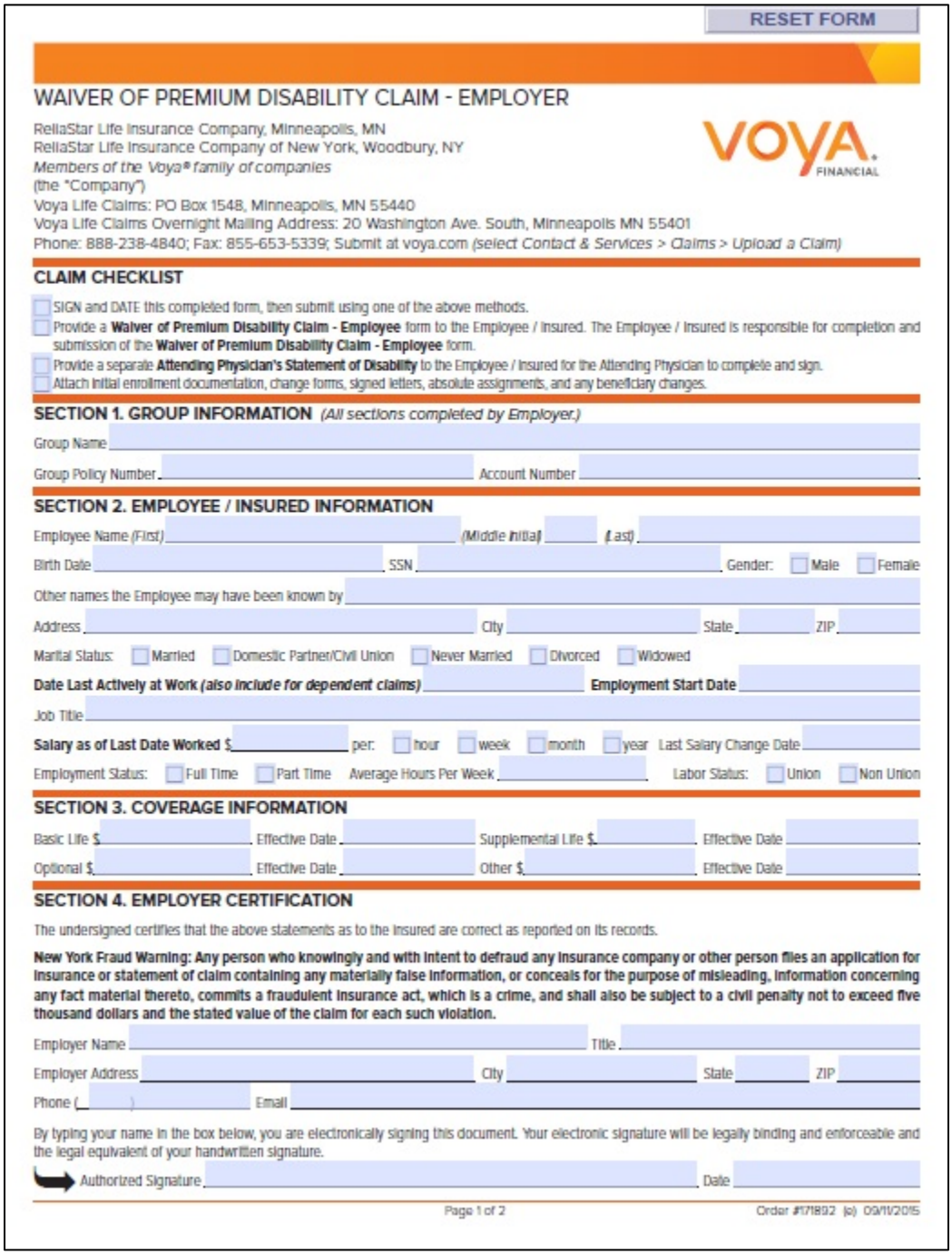
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

Waiver of Premium Disability Claim



RESET FORM

WAIVER OF PREMIUM DISABILITY CLAIM - EMPLOYER

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440
Voya Life Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis MN 55401
Phone: 888-238-4840; Fax: 855-653-5339; Submit at voya.com *(select Contact & Services > Claims > Upload a Claim)*

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ Provide a **Waiver of Premium Disability Claim - Employee** form to the Employee / Insured. The Employee / Insured is responsible for completion and submission of the **Waiver of Premium Disability Claim - Employee** form.
- ☐ Provide a separate **Attending Physician's Statement of Disability** to the Employee / Insured for the Attending Physician to complete and sign.
- ☐ Attach initial enrollment documentation, change forms, signed letters, absolute assignments, and any beneficiary changes.

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

Group Name _____

Group Policy Number _____ Account Number _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

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

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Other names the Employee may have been known by _____

Address _____ City _____ State _____ ZIP _____

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 Title _____

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

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

SECTION 3. COVERAGE INFORMATION

Basic Life $_____ Effective Date _____ Supplemental Life $_____ Effective Date _____

Optional $_____ Effective Date _____ Other $_____ Effective Date _____

SECTION 4. 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.

Employer Name _____ Title _____

Employer Address _____ City _____ State _____ ZIP _____

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 _____

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