

# DEATH CLAIM FOR ASSOCIATION 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")



**Submit at voya.com** (select *Contact & Services > Claims Center > Upload a Claim*);

**Phone:** 888-238-4840

**Voya Life Claims:** PO Box 1548, Minneapolis, MN 55440; **Overnight Address:** 20 Washington Ave. South, Minneapolis, MN 55401

## CLAIM CHECKLIST

- SIGN and DATE this completed form, then submit using one of the above methods.
- Provide the appropriate **Proof of Death - Claimant's Statement** to the beneficiary(ies).
- Attach the enrollment documentation, any beneficiary change documentation and a death certificate indicating manner and cause of death (a certified death certificate is required if the benefit is above \$500,000 or upon request).

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

Association Name \_\_\_\_\_  
Association Policy Number \_\_\_\_\_ Account Number \_\_\_\_\_ Claim Number \_\_\_\_\_

## SECTION 2. MEMBER / INSURED INFORMATION

Association Member  Spouse  
Insured Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_  
Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Gender:  Male  Female  
Other names the insured may have been known by \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (\_\_\_\_\_) \_\_\_\_\_ Marital Status:  Married  Domestic Partner / Civil Union  Never Married  Divorced  Widowed  
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 Member / Insured:  Spouse  Domestic Partner/Civil Union  Child / Stepchild  
Effective Date This Dependent Was Insured \_\_\_\_\_ Dependent Phone (\_\_\_\_\_) \_\_\_\_\_  
Dependent Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_  
Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Gender:  Male  Female  
Is the address the same as Insured?  Yes  No *(If "no," provide address below.)*  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## SECTION 3. COVERAGE INFORMATION

Certificate Number \_\_\_\_\_ Amount \$ \_\_\_\_\_  
Effective Date \_\_\_\_\_ Premium Paid to Date \_\_\_\_\_

Certificate Number \_\_\_\_\_ Amount \$ \_\_\_\_\_  
Effective Date \_\_\_\_\_ Premium Paid to Date \_\_\_\_\_

Certificate Number \_\_\_\_\_ Amount \$ \_\_\_\_\_  
Effective Date \_\_\_\_\_ Premium Paid to Date \_\_\_\_\_

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

Only complete this information for the **Guaranteed Issue Senior Term Life** product; otherwise, leave blank.

Effective Date \_\_\_\_\_ Decedent's Amount of Insurance as of Effective Date \$ \_\_\_\_\_

Amount of Premium Paid since the Effective Date of Coverage through the Date of this Claim:

(Include all premium paid for member and spouse coverage, if applicable.) \$ \_\_\_\_\_

Amount of Premium Paid Only for the Decedent \$ \_\_\_\_\_

Multiply Premium Paid for Decedent by a Factor of 1.25 \_\_\_\_\_

Was the optional \$10,000 Accidental Death Benefit elected?  Yes  No

Insured Name \_\_\_\_\_ Association Policy Number \_\_\_\_\_

## SECTION 4. ADMINISTRATOR 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 website, [Voya.com/us/businesses/employeebenefits/formslibrary/deathclaims/index.htm](http://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.**


Administrator Name \_\_\_\_\_ Title \_\_\_\_\_

Administrator Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Method of Underwriting Type for Life Insurance (*Select one.*):  Guaranteed Issue  Simplified Issue  Fully Underwritten  Unknown

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.