Employer's Statement **must** be sent to:

Minnesota Bankers Association
8050 Washington Ave South
Eden Prairie, MN 55344

Fax 952-857-2685
Email: stacym@minnbankers.com

*Significant delays will occur if the claim is not sent directly to Minnesota Bankers Association

RESET FORM

DISABILITY INCOME INSURANCE 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")
Disability RMS is the claims administrator on behalf of the Company.
300 Southborough Drive, Suite 200, South Portland, ME 04106-6914
Phone: 888-305-0602; Fax: 888-305-0605
Submit at voya.com *(select Contact & Services > Claims Center > Upload a Claim)*

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ Provide the **Disability Income Insurance Claim - Employee** form to the Employee / Insured. The Employee / Insured is responsible for completion and submission of the **Disability Income Insurance Claim - Employee** form.
- ☐ Provide a separate **Attending Physician's Statement** to the Employee / Insured for the Attending Physician to complete and sign.
- ☐ Section 5 (Waiver of Premium) should be completed ONLY if Life Insurance with Waiver of Premium is included in the Employee's Benefits Package.
- ☐ Attach a copy of the following documents to this form: Employee's Workers' Compensation claim(s) and Approval/Denial Notification; Employee's prior year's W-2 form OR if no W-2 is available, list the basic monthly earnings for the past 12 months just prior to the employee's date of disability; Employee's current job description.

SECTION 1: GROUP INFORMATION

Group Name Minnesota Bankers Association

Group Policy Number 70293-5 Disability Account Number _____

SECTION 2: EMPLOYEE / INSURED INFORMATION

Employee / Insured Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Other names the Employee may have been known by _____

Phone (_____)_____ Email _____

Address _____ City _____ State _____ ZIP _____

Employment Start Date _____ Coverage Effective Date _____

Date Disability Began _____ Date Last Worked _____

How many hours per week did the Employee normally work? _____ What type of shift? _____

Was Employee late enrollee? . . . . . ☐ Yes ☐ No

Salary $_____ per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Prior Year W-2 Parsonage $_____ OR _____%

Commissions *(If "Yes," attach list of commissions.)*. . . . . ☐ Yes ☐ No

Last Salary Change Date _____ Earnings Prior to Increase $_____

Is a layoff planned at Employee's location? . . . . . ☐ Yes ☐ No

Does the employee pay for any part of the premium? *(If "Yes," attach a copy of signed Enrollment form.)* . . . . . ☐ Yes ☐ No

Occupation/Duties ***(Attach a copy of Employee's job description.)*** _____

The Employee is filing a claim for the following type of disability *(Select one.)*: ☐ Long Term Disability ☐ Short Term Disability

Is disability work-related? . . . . . ☐ Yes ☐ No

If "Yes," has a Workers' Compensation claim been filed? . . . . . ☐ Yes ☐ No

Has employment been terminated? . . . . . ☐ Yes ☐ No

If "Yes," provide date and reason. _____

Has Employee returned to work? . . . . . ☐ Yes ☐ No

If "Yes," provide date and select the status. _____ Status: ☐ Full Time ☐ Part Time

Is employee subject to FICA tax? . . . . . ☐ Yes ☐ No

If "Yes," is employee subject to: ☐ Full FICA tax ☐ Medicare portion only

Percentage of employee/employer contribution to premium for this disability plan (as of policy year of disability):

Employee: ☐ 100% ☐ Other _____% Employer: ☐ 100% ☐ Other _____%

Is Employee Contribution: ☐ Pre-tax deduction ☐ After-tax deduction

Order #171335 (e) 07/11/2017

Employee / Insured Name _____ Group Policy Number 70293-5 Disability

SECTION 2: EMPLOYEE / INSURED INFORMATION

Is Employee / Insured eligible for or receiving:			Benefits			Paid	
Yes	No		Amount	Date Began	Date Terminated	Weekly	Monthly
☐	☐	Sick Pay?	$			☐	☐
☐	☐	Salary Continuance Benefits?	$			☐	☐
☐	☐	Workers' Compensation?	$			☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan?	$			☐	☐
☐	☐	No Fault?	$			☐	☐
☐	☐	Unemployment Compensation Disability?	$			☐	☐
☐	☐	Social Security Benefits (Disability or Retirement)?	$			☐	☐
☐	☐	Retirement income (Normal, Early, or Disability)?	$			☐	☐
☐	☐	Other LTD/STD Benefits?	$			☐	☐
☐	☐	Veterans Benefits?	$			☐	☐
☐	☐	Vacation?	$			☐	☐
☐	☐	Paid Time Off?	$			☐	☐
☐	☐	Other? Describe.	$			☐	☐

Were deductions for this coverage taken on a pre-tax basis? . . . . . ☐ Yes ☐ No

SECTION 3: REMARKS

SECTION 4: APPROVED FMLA DATES

FMLA Begin Date _____ FMLA Approved Through Date _____

SECTION 5: WAIVER OF PREMIUM *(Complete this section ONLY if Life Insurance with Waiver of Premium is included in the Employee's Benefits Package. See certificate for age requirement to be eligible for waiver.)*

Group Name Minnesota Bankers Association

Group Policy Number _____ Account Number _____ Labor Status: ☐ Union ☐ Non-Union

Amount of Employee's Insurance:

Basic Insurance Coverage $_____ Effective Date _____

Optional Insurance Coverage $_____ Effective Date _____

Supplemental Insurance Coverage $_____ Effective Date _____

Other Insurance Coverage $_____ Effective Date _____

SECTION 6: 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.

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.

Employer Name _____ Title _____

Employer Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Email _____

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.

Employee's Statement **must** be sent to:

Minnesota Bankers Association
8050 Washington Ave South
Eden Prairie, MN 55344

Fax 952-857-2685
Email: stacym@minnbankers.com

*Significant delays will occur if the claim is not sent directly to Minnesota Bankers Association

RESET FORM

DISABILITY INCOME INSURANCE CLAIM - EMPLOYEE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Disability RMS is the claims administrator on behalf of the Company.
300 Southborough Drive, Suite 200, South Portland, ME 04106-6914
Phone: 888-305-0602; Fax: 888-305-0605
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.
☐ The **Authorization for Release of Health-Related Information** must be completed and signed.
☐ The **Attending Physician's Statement** must be completed and signed by the Attending Physician and submitted with this form.

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

Group Name Minnesota Bankers Association

Group Policy Number 70293-5 Disability Policy / Certificate Number _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

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

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Email _____

Number Of Dependent Children _____ Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widowed

SECTION 3. INSURED STATEMENT

I am applying for the following type of disability *(Select one.)*: ☐ Long Term Disability ☑ Short Term Disability

Cause of Disability _____ Is Spouse Employed? ☐ Yes ☐ No

Height _____ ft. _____ in. Weight _____ lbs. Hand Dominance: ☐ Right-hand ☐ Left-hand

List names and birth dates of spouse and dependent children in the table below. *If additional space is required attach a separate document.*:

Name *(First, MI, Last)*	Birth Date	Gender	Relationship
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Date Last Worked _____ Date of Disability _____

Employer Name _____ Phone (_____)_____

Address _____ City _____ State _____ ZIP _____

Occupation _____

List of Duties _____

How many hours were you regularly working per week with your present employer? _____

Gross Annual Salary *(during the 12 months immediately prior to your disability - for this employer only)* $_____

Other than this group plan, have you been covered under any other group disability income plan within the past 2 years? . . . . . ☐ Yes ☑ No

If "Yes," indicate the type of disability coverage you had under that group plan: ☐ Weekly Income Benefits (Short Term Disability) ☐ Monthly Income Benefits (Long Term Disability)

Name of employer, union or other organization that sponsored that group plan _____

Employee / Insured Name _____ Policy / Certificate Number _____

SECTION 3. INSURED STATEMENT *(Continued)*

On what date did you first see a physician for this illness or injury? _____

Physician Name _____ Phone (_____)_____

Address _____ City _____ State _____ ZIP _____

If hospitalized for this illness or injury, provide name and address of hospital. _____

Admitted Date _____ Released Date _____

Who is your regular, (i.e., your primary) Physician? _____

Physician Name _____ Phone (_____)_____

Address _____ City _____ State _____ ZIP _____

If disability resulted from accident, answer these questions:

Was disability caused by a motor vehicle accident? . . . . . ☐ Yes ☐ No

Was accident work related? . . . . . ☐ Yes ☐ No

If "Yes," have you applied for Workers' Compensation? . . . . . ☐ Yes ☐ No

Accident Date _____ Where did accident occur? _____

Provide details of how it occurred. _____

Have you ever had the same kind of illness or injury before? . . . . . ☐ Yes ☐ No

If "Yes," provide the date of illness, physician's name, address and telephone number. Date _____

Physician Name _____ Phone (_____)_____

Address _____ City _____ State _____ ZIP _____

SECTION 4. FOR PREGNANCY DISABILITY ONLY

Are there any present complications or anticipated difficulties in connection with:

(a) Pregnancy . . . . . ☐ Yes ☐ No

Date of Last Menstrual Period _____ Expected Date of Delivery _____

(b) Delivery . . . . . ☐ Yes ☐ No

Actual Delivery Date _____ Delivery Type: ☐ Vaginal ☐ C-Section

(c) Post Partum . . . . . ☐ Yes ☐ No

If "Yes," to any of these, specify in detail. _____

Employee / Insured Name _____ Policy / Certificate Number _____

SECTION 5. EMPLOYEE / INSURED COMPENSATION INFORMATION

Is Employee / Insured eligible for or receiving:			Benefits			Paid		Applied For		
Yes	No		Amount	Date Began	Date Terminated	Weekly	Monthly	Yes	No	Date
☐	☐	Sick Pay?	$			☐	☐	☐	☐	
☐	☐	Salary Continuance Benefits?	$			☐	☐	☐	☐	
☐	☐	Workers' Compensation?	$			☐	☐	☐	☐	
☐	☐	Local, State or National Association or Society Disability Income Plan?	$			☐	☐	☐	☐	
☐	☐	No Fault?	$			☐	☐	☐	☐	
☐	☐	Unemployment Compensation Disability?	$			☐	☐	☐	☐	
☐	☐	Social Security Benefits (Disability or Retirement)?	$			☐	☐	☐	☐	
☐	☐	Retirement income (Normal, Early, or Disability)?	$			☐	☐	☐	☐	
☐	☐	Other STD/LTD Benefits?	$			☐	☐	☐	☐	
☐	☐	Veterans Benefits?	$			☐	☐	☐	☐	
☐	☐	Vacation?	$			☐	☐	☐	☐	
☐	☐	Paid Time Off?	$			☐	☐	☐	☐	
☐	☐	Other? Describe.	$			☐	☐	☐	☐	

Are you currently working? . . . . . ☐ Yes ☐ No

If "Yes," provide the date you returned to work *(including year.)* _____ How many hours per day are you working? _____

If "No," when do you expect to return to work? _____ What is the date of your next office visit? _____

SECTION 6. EMPLOYEE / INSURED CERTIFICATION

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the insurance company to the extent of any overpayment which is in excess of the amounts payable under this group plan.

(See Section 7 for Signature.)

Employee / Insured Name _____ Policy / Certificate Number _____

SECTION 7. AUTHORIZATION FOR RELEASE OF INFORMATION *(Excluding psychotherapy notes. HIPAA Compliant. To be signed and dated by the insured/claimant.)*

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency including the Social Security Administration, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of ReliaStar Life Insurance Company *excluding psychotherapy notes,* and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by ReliaStar Life Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim. The information may be re-disclosed to: (a) any medical, investigative, financial or vocational specialist or entity, or any other organization or person, employed by or representing ReliaStar Life Insurance Company, to assist with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand ReliaStar Life Insurance Company and the above-described representatives may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying ReliaStar Life Insurance Company in writing, of my revocation. However, such revocation is not effective to the extent ReliaStar Life Insurance Company has relied previously upon this authorization for the use or disclosure of my protected health information. I understand ReliaStar Life Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair ReliaStar Life Insurance Company's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

*If you reside in **California**: this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

If you reside in **Connecticut, Maine, or Massachusetts: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

***If you reside in **Vermont**: this authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING ReliaStar Life Insurance Company to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and ReliaStar Life Insurance Company shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

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.

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.

Insured Name _____ Birth Date _____

Insured Signature *(or Authorized Representative [1])* _____ Date _____

Description of Personal Representative's Authority (If applicable) _____

[1] If signed by Authorized Representative, attach verification of identity

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.

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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.

ELECTRONIC FUND TRANSFER AUTHORIZATION (DIRECT DEPOSIT)[1]

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya family of companies
(the "Company")
Voya Employee Benefits: PO Box 1290, Minneapolis, MN 55440-1290
Toll-Free: 800-328-4090

I hereby authorize the Company to initiate deposit to checking OR savings account as indicated below and the depository named below to credit same to such account.

Bank Name _____ Phone (_____)_____

Bank Address _____

City _____ State _____ ZIP _____

Routing Number (ABA) *(9 digits)* _____ Account Number _____

Account type: ☐ Checking ☐ Savings

This authority is to remain in full force and effect until the Company has received written notification from me of its termination/change in such manner as to afford the Company as reasonable opportunity to act on it.

Name *(please print)* _____

Signature _____ Date _____

SSN _____ Policy Number_____

Attach a blank check marked void (Deposit slips not acceptable)

Tape voided check or deposit slip here.

Please allow 6-8 weeks for processing.

[1]*Available within the USA on payments made to plan participants only.*

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

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

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

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

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

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

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

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

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

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

Notice Regarding MIB, Inc.
We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Attending Physician's Statement **must** be sent to:

Minnesota Bankers Association
8050 Washington Ave South
Eden Prairie, MN 55344

Fax 952-857-2685
Email: stacym@minnbankers.com

*Significant delays will occur if the claim is not sent directly to Minnesota Bankers Association

RESET FORM

SHORT TERM DISABILITY INCOME ATTENDING PHYSICIAN'S STATEMENT OF IMPAIRMENT AND FUNCTION

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")
Disability RMS is the claims administrator on behalf of the insurance company.
300 Southborough Drive, Suite 200, South Portland, ME 04106-6914
Phone: 888-305-0602; Fax: 888-305-0605
Submit at voya.com *(select Contact & Services > Claims > Upload a Claim)*

The patient is responsible for the completion of this form without expense to the Company.

CLAIM CHECKLIST

- ☐ This completed form must be submitted using one of the above methods.
- ☐ The Insured must complete Sections 1 and 2.
- ☐ The Attending Physician must complete Sections 3 - 12.

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

Group Name Minnesota Bankers Association Group Policy Number 70293-5 Disability

SECTION 2. INSURED / PATIENT INFORMATION

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

Patient Birth Date _____

Address _____ City _____ State _____ ZIP _____

Under the Short Term Disability Income Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of his/her **own occupation** and meets contractual requirements.

SECTION 3. PRESENT CONDITION

Height _____ ft. _____ in. Weight _____ lbs. Hand Dominance: ☐ Right-hand ☐ Left-hand

In order to determine benefit eligibility and rehabilitation, please answer the following:

When did symptoms first appear or accident happen? _____

On what date did the Patient cease work because of disability? _____

Has Patient ever had the same or similar condition? . . . . . ☐ Yes ☐ No

Did another Physician refer this Patient to you?. . . . . ☐ Yes ☐ No

If "Yes," please provide the name and address of the referring Physician. _____

Subjective Symptoms _____

Objective Findings _____

Primary Diagnosis _____ ICD-10 Code(s) _____

Secondary Conditions _____

Has Patient been confined to a hospital? . . . . . ☐ Yes ☐ No

If "Yes," provide dates. _____

Has Patient had surgery? . . . . . ☐ Yes ☐ No

If "Yes," provide dates. _____

Surgery Type _____ CPT Code(s) _____

Prognosis _____

SECTION 4. CURRENT PLAN OF TREATMENT

Date of First Visit _____ Date of Last Visit _____ Next Scheduled Appointment _____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Treatment Plan _____

SECTION 5. FOR PREGNANCY DISABILITY ONLY

Date First Treated _____ Estimated Date of Confinement (EDC) _____ Type of Delivery: ☐ Vaginal ☐ C-Section

Has Patient Delivered? ☐ Yes ☐ No If "Yes," provide delivery date. _____ Post Partum Recovery Weeks: ☐ 6 ☐ 8

Order #115533 (e) 11/18/2015

Patient Name _____ Group Policy Number 70293-5 Disability

SECTION 6. EXTENT OF DISABILITY

Is Patient totally disabled from performing the duties of their own occupation? . . . . . ☐ Yes ☐ No

If the disability is not considered total and permanent, do you anticipate a release to their OWN occupation? . . . . . ☐ Yes ☐ No

If "Yes," when? _____

If "No," do you anticipate a release to a less physically and/or emotionally demanding occupation? . . . . . ☐ Yes ☐ No

If "Yes," when? _____

If the Patient cannot perform the duties of their own occupation, would you feel it appropriate to consider Vocational and/or Medical Rehabilitation? . . . . . ☐ Yes ☐ No

If the Patient is disabled from his/her own occupation but appropriate for rehabilitation or a release to a less demanding occupation, complete Section 10 (Physical Capacity Evaluation) on this form. This is used to lend direction in exploring medical/vocational alternatives.

SECTION 7. COMPETENCY

Is the Patient competent to endorse checks and direct the use of the proceeds? . . . . . ☐ Yes ☐ No

SECTION 8. CARDIAC FUNCTIONAL CAPACITY *(Complete this section IF disability is due to Cardiac Condition.)*

American Heart Association Classification: ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

Blood Pressure _____

SECTION 9. VISUAL IMPAIRMENT *(Complete this section IF disability is due to Visual Impairment.)*

What was vision at last observation? (Snellen Notation)

With Glasses O. D. _____ O.S. _____ Date _____

Without Glasses O. D. _____ O.S. _____ Date _____

SECTION 10. PHYSICAL CAPACITIES EVALUATION *(Important: Please complete the following items based on your clinical evaluation, other testing results, Patient discussions, and/or job analysis. Any item that you do not believe you can answer should be marked N/A (not available).*

NOTE: In terms of an eight hour workday, "Occasionally" equals zero to 33 percent; "Frequently" equals 34-66 percent; "Continuously" equals 67-100 percent.

In an eight hour work day, Patient can:

Sit (hours):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
Stand (hours):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
Walk (hours):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

If any of the above three capabilities require alternating positions, please indicate frequency. _____

Patient can lift:	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Patient can carry:	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

SECTION 10. PHYSICAL CAPACITIES EVALUATION *(Continued)*

Patient is able to:	Never	Occasionally	Frequently	Continuously
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐

Restrictions on activities involving:	None	Mild	Moderate	Total
Unprotected heights	☐	☐	☐	☐
Being around moving machinery	☐	☐	☐	☐
Exposure to marked changes in temperature and humidity	☐	☐	☐	☐
Driving automotive equipment	☐	☐	☐	☐
Exposure to dust, fumes, or gasses	☐	☐	☐	☐

Patient can use hands for repetitive action such as:	Right		Left	
	Yes	No	Yes	No
Simply Grasping	☐	☐	☐	☐
Pushing and Pulling	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐

Patient can use feet for repetitive movements, as in operating foot controls:	Yes	No
Right	☐	☐
Left	☐	☐
Both	☐	☐

SECTION 11. REMARKS

SECTION 12. PHYSICIAN INFORMATION AND SIGNATURE

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.

Attending Physician Name *(Please print.)* _____ Degree _____

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

Email _____

Address _____ City _____ State _____ ZIP _____

Attending Physician 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.