WAIVER OF PREMIUM DISABILITY CLAIM (NY)

ReliaStar Life Insurance Company of New York, Woodbury, NY
A member of the Voya family of companies
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440, Toll-Free: 888-238-4840

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.

The Group, Employee, Claim Information and Certification sections must be completed by the employer. The Insured is responsible for completion of the remainder of the form. The separate Attending Physician's Statement must be completed by the Insured's attending physician. The completed forms must be sent to the above address, along with copies of the Insured's enrollment forms, change forms, signed letters, absolute assignments, and beneficiary changes.

GROUP POLICYHOLDER INFORMATION

Group Policyholder _____

Group Policy Number _____ Account Number _____

EMPLOYEE INFORMATION

Insured Name _____

Birth Date _____ SSN _____

Address _____

City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widow(er) Gender: ☐ Male ☐ Female

Job Title _____ Employment Start Date _____ Date Last Worked _____

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

Employment Status: ☐ Full Time ☐ Part Time If part-time, average hours per week _____ ☐ Union ☐ Non Union

CLAIM INFORMATION

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

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

EMPLOYER CERTIFICATION

The undersigned certifies that the above statements as to the insured are correct as reported on its records.

Employer Name _____

Employer Address _____

City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Title _____ Phone (_____)_____ E-mail _____

INSURED STATEMENT *(Use separate sheet to provide additional information if needed.)*

Describe condition or illness _____

Attending Physician Name *(please print)* _____ Date _____

Address _____

City _____ State _____ ZIP _____

Cause _____

Insured Name _____ SSN _____ Group Policy Number _____

INSURED STATEMENT *(Continued)*

Other Attending Physician Name *(please print)* _____ Date _____

Address _____

City _____ State _____ ZIP _____

Cause _____

Date You Last Worked _____ Date You Became Totally Disabled _____

Are you receiving any other disability benefits? . . . . . ☐ Yes ☐ No

If "Yes," what type? _____

Are you house confined? . . . . . ☐ Yes ☐ No

Are you bed confined? . . . . . ☐ Yes ☐ No

Are you receiving any wages or salary? . . . . . ☐ Yes ☐ No

If "Yes," what type? _____

Have you returned to work? . . . . . ☐ Yes ☐ No

If "Yes," what date? _____

Do you expect to return to work? . . . . . ☐ Yes ☐ No

If "Yes," what date? _____

EDUCATIONAL BACKGROUND *(Please check the highest grade completed.)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ AA ☐ AS ☐ BA ☐ BS ☐ MA ☐ Ph.D ☐ Other _____

AUTHORIZATION AND ACKNOWLEDGMENT

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, Medical Information Bureau, Inc. (MIB), Social Security Administration or employer to give ReliaStar Life Insurance Company of New York ("the Company") or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), 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. I give my permission to the Company to get consumer or investigative consumer reports about me.

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.

I hereby certify that the statements on this form are complete and accurate to the best of my knowledge.

Insured Signature _____ Date _____

Home Phone (_____)_____ Home E-mail _____