CLAIM SUBMISSION - EMPLOYEE

ReliaStar Life Insurance Company, Minneapolis, MN
Members of the Voya® family of companies
(the "Company")
Submit at voyaprotectsupport@joinansel.com
Fax: (302) 549-4340.
Voya Protect: 2093 Philadelphia Pike #6462 Claymont, DE 19703
Attention: Claims Department

It just takes a few minutes to submit a claim online at https://myvoyaprotect.voya.com or through the Voya Protect app. You'll enjoy faster processing time, and we'll send you updates on your claim electronically.

If you'd rather not file a claim online, you can use this paper form to submit your claim to us by mail or fax.

How to use this form

Please read all instructions and be sure to completely fill out the form. If you provide an incomplete claims submission, this could delay the processing of your claim.

- Do not write on the form except as instructed.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Sign, date, and fax or mail your completed claim submission, along with your supporting documentation, to the Voya Protect fax number/address shown below.

In addition to the claim form, please submit four supporting documents that confirm your claim, including the condition(s) you had and the date you were diagnosed. If you don't have four documents, send us at least two documents. A Voya Protect Member Care Representative will be in touch with you if we need more information. Here are examples of the types of supporting documentation you can submit:

- Hospital discharge paperwork
- Summary of care
- Statement of benefits
- Ambulance call report
- Image of hospital wristband
- Image of a prescription for medication
- Image of a prescription medication bottle
- A doctor's bill
- A medical facility bill
- A lab bill
- Lab reports
- Test results
- Imaging results

If you'd like us to work directly with your providers to request additional documentation, please complete the HIPAA Authorization Form attached and submit it with your claim and supporting documentation.

Mail your complete claim submission form and supporting documentation to us at:

Voya Protect
Administered by Ansel Services, Inc.
Attn: CLAIMS
2093 Philadelphia Pike #6462
Claymont, DE 19703

You can also fax your documents to the Voya Protect Claims Department at 1 (302) 549-4340.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member. You can find an electronic version of this form at https://myvoyaprotect.voya.com or you can request additional forms by calling Voya Protect Member Services at (888) 290-1153.

¿Necesitas ayuda en español? Llama al (888) 290-1153 para recibir ayuda.

SECTION 1. CLAIMANT INFORMATION

The claimant is the Voya Protect member for whom this claim is being submitted.

First Name _____ Middle Name _____ Last Name _____

Suffix _____ Relationship to Primary Member _____

Birth Date _____ SSN _____ Primary Member's Employer _____

Address _____

City _____ State _____ ZIP _____

Phone (_____)_____ May we leave a message at this number? ☐ Yes ☐ No

SECTION 2. EMPLOYEE INFORMATION

The primary Voya Protect member is the person who enrolled in Voya Protect at work. You may write 'same as above' if you are a primary member filing a claim for yourself.

First Name_____ Last Name _____

Birth Date _____ SSN _____ Employer Name _____

SECTION 3. TELL US WHAT HAPPENED

Answer each question below and be as specific as possible.

What symptoms did you experience?

_____

_____

_____

What did your provider tell you was wrong?

_____

_____

_____

What treatment did you receive?

_____

_____

_____

Is there anything else we should know?

_____

_____

_____

_____

SECTION 3. TELL US WHERE YOU WERE TREATED

Name of Treatment Facility (you may list multiple):

_____

_____

Type(s) of Facility: (check all that apply) ☐ Doctor's Office ☐ Urgent Care ☐ Hospital Inpatient ☐ Emergency Room ☐ Outpatient Surgery

Other: _____ Date of Service: _____

By signing below, you attest that you have provided truthful information on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

*****NOTICE – See State-Specific Fraud Notices on Last Page*****

Claimant Signature (or Authorized Representative) _____

Claimant Name (please print) _____ Date _____

Representative Relationship to Claimant _____

SECTION 4. AUTHORIZATION AND ACKNOWLEDGMENT

AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF INSURANCE CLAIM DETERMINATION

Name of Insured _____ Birth Date _____

Address _____

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided treatment or services to me or on my behalf within the past 2 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to ReliaStar Life Insurance Company (Voya) and to their third-party administrator, Ansel Services, Inc. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (*HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Voya may administer claims and determine or fulfill responsibility for coverage and provision of benefits.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: **Voya Protect** 2093 Philadelphia Pike #6462 Claymont, DE 19703 Attention: Claims Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that Voya has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Voya may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Individual Whose Information is to be Disclosed or Authorized Representative

_____

Print Name of Individual or Authorized Representative Date Signed

Return form by email to voyaprotectsupport@joinansel.com or by mail to **Voya Protect** Attn: Claims, 2093 Philadelphia Pike #6462 Claymont, DE 19703 or by fax to 1 (302) 549-4340.

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 information to obtain or amend insurance coverage or to make a 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.