

# ATTENDING PHYSICIAN'S STATEMENT OF COMPASS CRITICAL ILLNESS

ReliaStar Life Insurance Company, Minneapolis, MN  
A member of the Voya™ family of companies  
(the "Company")

Voya Claims: PO Box 1548, Minneapolis, MN 55440

Voya Claims Overnight Mailing Address: 20 Washington Avenue South, Minneapolis MN 55401

Toll-Free: 888-238-4840; Fax: 855-653-5339; Email: VoyaClaims@voya.com



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

## CLAIM CHECKLIST

- This completed form must be sent, faxed or emailed to the above address.
- The Employee/Insured must complete Sections 1 and 2.
- Be sure to have the attending physician complete Sections 3 - 6.

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

Group Name \_\_\_\_\_ Group Policy Number \_\_\_\_\_

## SECTION 2. EMPLOYEE / INSURED INFORMATION

Patient Name *(Last, First, Middle Initial)* \_\_\_\_\_

Birth Date \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Employee Name *(if different than Patient Name)* \_\_\_\_\_

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

## SECTION 3. PRESENT CONDITION

Applicable Critical Illness:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Alzheimer's Disease                 | <input type="checkbox"/> Carcinoma in Situ                | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) | <input type="checkbox"/> Coma                             | <input type="checkbox"/> Infectious Disease  | <input type="checkbox"/> Permanent Paralysis |
| <input type="checkbox"/> Benign Brain Tumor                  | <input type="checkbox"/> Coronary Artery Bypass           | <input type="checkbox"/> Major Organ Failure | <input type="checkbox"/> Skin Cancer         |
| <input type="checkbox"/> Blindness                           | <input type="checkbox"/> Deafness                         | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> End Stage Renal (Kidney) Failure | <input type="checkbox"/> Occupational HIV    |  |

Additional Child Diseases:  Cerebral Palsy  Congenital Birth Defects  Cystic Fibrosis  Down Syndrome

## SECTION 4. HISTORY

When did the current symptoms first appear? \_\_\_\_\_ Confirmed Diagnosis Date \_\_\_\_\_

Has the patient ever had the same or a similar condition? *(If "Yes," provide date and description.)*  Yes  No

## SECTION 5. TREATMENT DETAILS

### Alzheimer's Disease

Does the patient have an inability to perform 2 or more Activities of Daily Living? . . . . .  Yes  No

Was the diagnosis clinically established by testing? . . . . .  Yes  No

If "Yes," select testing method:  MRI  CT *(Attach test results.)*

### ALS

Diagnosis established by:  MRI  Nerve biopsy  EMG  Neurological exam *(Attach test results.)*

### Benign Brain Tumor

Has a biopsy been performed to confirm diagnosis?  Yes  No Type of Tumor \_\_\_\_\_ *(Attach test results.)*

### Blindness

What was vision at last observation? *(Snellen Notation)*

• with glasses O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Date \_\_\_\_\_

• without glasses O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Date \_\_\_\_\_

Date corrected vision was irrecoverably reduced to 20/200 or less in the better eye \_\_\_\_\_  O.D.  O.S.

**SECTION 5. TREATMENT DETAILS** (Continued)

**Cancer/Carcinoma in Situ**

Was the cancer/carcinoma in situ pathologically diagnosed (*attach copy of report*) or clinically diagnosed? \_\_\_\_\_

If clinically diagnosed, provide reason that pathological diagnosis not obtained and attach medical evidence that supports the diagnosis of cancer.

**Coma**

Has patient experienced a continuous state of unconsciousness for 14 or more consecutive days? . . . . .  Yes  No

Did patient require intubation? . . . . .  Yes  No

Was there an absence of eye opening, verbal response and motor response? . . . . .  Yes  No

**Coronary Artery Bypass**

Did or will the patient undergo open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts? . .  Yes  No  
(*Attach operative report.*)

What condition caused the need for coronary artery bypass surgery? \_\_\_\_\_

**Deafness**

Is hearing loss profound, permanent and not correctable? . . . . .  Yes  No (*Attach test results.*)

**End Stage Renal (Kidney) Failure**

Does the patient have end stage renal failure presenting as chronic, irreversible failure to function of both kidneys? . . . . .  Yes  No

Does the patient's kidney failure necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly) or which results in kidney transplantation? . . . . .  Yes  No

Is patient on UNOS (United Network for Organ Sharing) list for a transplant? . . . . .  Yes  No

What is the cause for the patient's renal disease? \_\_\_\_\_

**Heart Attack**

Does the patient's condition meet all of the following criteria:

1. Are new and serial electrocardiographic (EKG) findings consistent with myocardial infarction? . . . . .  Yes  No

2. Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine phosphokinase (CPK) or elevated troponins? (*If "Yes," attach confirmatory lab reports.*) . . . . .  Yes  No

3. Did diagnostic studies confirm a myocardial infarction and the occlusion of one or more coronary arteries? . . . . .  Yes  No  
(*Attach copies of any applicable reports.*)

**Infectious Disease**

Was the patient confined to a hospital for 14 consecutive days? . . . . .  Yes  No

If "Yes," Type of Infectious Disease. \_\_\_\_\_ (*Attach lab test results.*)

**Major Organ Failure**

Did the patient undergo surgery to receive a human heart, liver, both lungs or pancreas? . . . . .  Yes  No (*Attach a copy of the operative report.*)

If operation has not been performed, is patient on UNOS (United Network for Organ Sharing) list for a transplant? . . . . .  Yes  No

What condition caused the need for the major organ transplant? \_\_\_\_\_

**Multiple Sclerosis**

Are symptoms persistent for 6 months? . . . . .  Yes  No (*Attach MRI and spinal fluid analysis.*)

**Occupational HIV**

Did the patient contract HIV at work and while performing normal occupational duties, from one of the following?  Accidental Needle Stick

Other Accidental Sharp Injury  Accidental Mucous Membrane Exposure to Blood or Bloodstained Bodily Fluid (*Attach lab results.*)

**Parkinson's Disease**

Does patient present any symptom or combination of 4 cardinal symptoms (*Check all that apply*)?

Rest tremor  Rigidity  Bradykinesia  Gait disturbance

**Permanent Paralysis**

Did patient have total and permanent loss of use of 2 or more limbs due to accident or sickness for a continuous period of at least 60 days which was not caused by stroke? . . . . .  Yes  No

Cause of paralysis \_\_\_\_\_

**Skin Cancer**

Please indicate type of skin cancer (*Attach pathology report.*)

Basal cell carcinoma  Squamous Cell  Melanoma diagnosed as Breslow's classification less than 0.75mm

**Stroke**

Did the patient have a stroke, meaning apoplexy, secondary to rupture or acute occlusion of a cerebral artery? Stroke does not include transient ischemic attacks, ischemic disorders of the vestibular system, brain injury related to trauma or infection, and brain injury associated with hypoxia / anoxia or hypotension. . . . .  Yes  No (*Attach confirmation test results.*)

Patient Name \_\_\_\_\_ Group Policy Number \_\_\_\_\_

**SECTION 5. TREATMENT DETAILS** *(Continued)*

**Cerebral Palsy**

Does child have any of the following group of development/movement disorders?

- Delayed Motor Development    Intellectual    Seizures    Speech    Vision/Hearing    Positive imaging testing of the brain  
 Others not listed

**Congenital Birth Defects**

Did the congenital birth defect result in the child being confined to a hospital for 30 days or more consecutively beginning within the first week after birth? . . . . .  Yes    No

If "Yes," check all that apply:

- Heart    Lungs    Spina Bifida    Cleft lip/palate    Limb malformations    Blindness    Developmental disorders of the brain

**Cystic Fibrosis**

Has a definite diagnosis been made from one of the following?

- Sweat test? . . . . .  Yes    No   *(If "Yes," attach two independent positive tests.)*  
Chest x-ray? . . . . .  Yes    No  
Lung Function Testing? . . . . .  Yes    No

**Down Syndrome**

Please check the confirmed diagnosis:    Trisomy 21    Translocation    Mosaic

**SECTION 6. PHYSICIAN INFORMATION AND SIGNATURE**

Attending Physician Name *(Please print.)* \_\_\_\_\_ Degree \_\_\_\_\_

TIN \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

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

 Attending Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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## 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.