RESET FORM

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 Stanislaus County Group Policy Number 685399

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:

☐ Alzheimer's Disease	☐ Carcinoma in Situ	☐ Heart Attack	☐ Parkinson's Disease
☐ Amyotrophic Lateral Sclerosis (ALS)	☐ Coma	☐ Infectious Disease	☐ Permanent Paralysis
☐ Benign Brain Tumor	☐ Coronary Artery Bypass	☐ Major Organ Failure	☐ Skin Cancer
☐ Blindness	☐ Deafness	☐ Multiple Sclerosis	☐ Stroke
☐ Cancer	☐ End Stage Renal (Kidney) Failure	☐ 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.

Patient Name _____ Group Policy Number 685399

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 physphokinase (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 685399

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 _____

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.