

# ATTENDING PHYSICIAN'S STATEMENT OF CRITICAL ILLNESS / SPECIFIED DISEASE

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



Voya Claims: PO Box 320, Minneapolis, MN 55440  
Voya Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis MN 55401  
Phone: 888-238-4840; Fax: 877-464-2280; Submit at [voya.com](http://voya.com) (select Contact & Services > Claims Center > Upload a Claim)

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

## CLAIM CHECKLIST

- SIGN and DATE this completed form, then submit using one of the above methods.
- The Employee / Insured / Member must complete Sections 1 and 2.
- Attach copies of all test results and operative reports.
- The Attending Physician must complete Sections 3 - 5.

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

Group / Association Name \_\_\_\_\_ Group / Association Policy Number \_\_\_\_\_  
Claim Number \_\_\_\_\_ Member ID Number *(for Association only)* \_\_\_\_\_

## SECTION 2. EMPLOYEE / INSURED / MEMBER INFORMATION

Patient Name *(First)* \_\_\_\_\_ *(Middle Initial)* \_\_\_\_\_ *(Last)* \_\_\_\_\_  
Patient Birth Date \_\_\_\_\_ Patient Phone (\_\_\_\_\_) \_\_\_\_\_  
Employee / Member Name; **if NOT Patient** *(First)* \_\_\_\_\_ *(Middle Initial)* \_\_\_\_\_ *(Last)* \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## SECTION 3. 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 4. CRITICAL ILLNESS / SPECIFIED DISEASE *(Only the conditions listed below may be covered. Any other condition not listed below is not an eligible condition.)*

**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: *(Attach test results.)*  MRI  CT

**Amyotrophic Lateral Sclerosis (ALS)**  
Diagnosis established by: *(Attach test results.)*  MRI  Nerve Biopsy  EMG  Neurological Exam

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

**SECTION 4. CRITICAL ILLNESS / SPECIFIED DISEASE (Continued)**

**Blindness**

What are the most recent visual acuity measurements?

With glasses (*in Snellen Notation*) O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Date \_\_\_\_\_

Without glasses (*in Snellen Notation*) O.D. \_\_\_\_\_ O.S. \_\_\_\_\_ Date \_\_\_\_\_

On what date was corrected vision irreversibly reduced to 20/200 or less in the better eye? \_\_\_\_\_  O.D.  O.S.

**Cancer/Carcinoma in Situ / Skin Cancer**

Cancer / Carcinoma In Situ was diagnosed using:  Pathological Diagnosis (*Attach copy of report.*) Stage of Cancer \_\_\_\_\_

Clinical Diagnosis (*Provide reason for not obtaining pathological diagnosis and attach medical evidence that supports the diagnosis of cancer.*)

Indicate Skin Cancer Type: (*Attach pathology report.*)  Basal Cell Carcinoma  Squamous Cell Carcinoma  Melanoma

**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? (*Attach operative report.*) .....  Yes  No

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

**Deafness**

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

**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? (*Attach copies of any applicable reports.*) .....  Yes  No

**Infectious Disease**

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

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

**Major Organ Failure**

Did the patient undergo surgery to receive a human heart, liver, both lungs, both kidneys or pancreas?

(*Attach a copy of the operative report.*) .....  Yes  No

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

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

**Multiple Sclerosis**

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

**SECTION 4. CRITICAL ILLNESS / SPECIFIED DISEASE (Continued)**

**Occupational HIV**

Did the patient contract HIV at work and while performing normal occupational duties, from one of the following? (*Attach lab results.*)

- Accidental Needle Stick     Other Accidental Sharp Injury     Accidental Mucous Membrane Exposure to Blood or Bloodstained Bodily Fluid

**Parkinson's Disease**

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

- Rest Tremor     Rigidity     Bradykinesia     Gait Disturbance

**Permanent Paralysis**

Did the 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 \_\_\_\_\_

**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, or brain injury associated with hypoxia / anoxia or hypotension. (*Attach confirmation test results.*) .....  Yes     No

**ADDITIONAL CHILDHOOD DISEASES**

**Cerebral Palsy**

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

- Delayed Motor Development     Intellectual     Seizures     Speech  
 Vision / Hearing     Positive Neuroimaging Test     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 Brain Disorders

**Cystic Fibrosis**

Was a definite diagnosis established by one of the following:?

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

**Down Syndrome**

Check the confirmed diagnosis:     Trisomy 21     Translocation     Mosaic

**SECTION 5. 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

**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.