Instructions for Filing a Hospital Indemnity Claim Form

Please complete the forms and return them to Risty Benefits with the following documentation:

1. Time and date of admission and discharge
2. Room and Board charges
3. Medical reason for admission

Hospitals normally have all the required information on a summary called a "**UB04**" form available in the hospital's business office.

You can return the documents via:

Email: help@ristybenefits.com, Fax: (605) 338-2823, or Mail:

Risty Benefits, Inc.
Attn: SD Claims Processing
PO Box 90335
Sioux Falls, SD 57109-0335

If you have questions, please call Risty Benefits toll free at (866) 237-9411.

Thank you!

RESET FORM

COMPASS HOSPITAL CONFINEMENT INDEMNITY CLAIM - EMPLOYEE

ReliaStar Life Insurance Company, Minneapolis, MN
A member 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 *(select Contact & Services > Claims Center > Upload a Claim)*

CLAIM CHECKLIST

☐ SIGN and DATE this completed form, then submit using one of the above methods.
☐ Attach a copy of the itemized hospital bill or other supporting documentation along with the **Attending Physician's Statement of Hospital Confinement Indemnity** indicating the diagnosis and the number of days hospitalized.
☐ Provide a copy of the police report for all motor vehicle accident claims and any other incidents investigated by any law enforcement agency.

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

Group Name State of South Dakota
Group Policy Number 68254-3 Account Number _____
Claim Number _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Address _____ City _____ State _____ ZIP _____
Phone (_____)_____ Email _____

If this claim is NOT for the employee, complete the following information:
Relationship to the Employee: ☐ Spouse ☐ Domestic Partner / Civil Union ☐ Child / Stepchild
Dependent Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Is the address the same as Employee? ☐ Yes ☐ No *(If "No," provide address below.)*
Address _____ City _____ State _____ ZIP _____

SECTION 3. HOSPITAL INFORMATION

Hospital Name _____
Date of Hospital Admission _____ Date of Hospital Discharge _____

SECTION 4. ADDITIONAL BENEFITS

Refer to your group policy to confirm coverage by any of the riders listed below. Select and provide the information requested for any claim(s) you are submitting.

☐ Accident Benefit Rider *(Attach copy of police report.)*
Date of Accident *(if applicable)* _____ Date of Initial Examination by Medical Provider _____
Medical Provider Name _____ Medical Provider Phone (_____)_____
Medical Provider Address _____ City _____ State _____ ZIP _____
If auto accident, was the Claimant a: ☐ Driver ☐ Passenger
Did this accident / injury happen at work? ☐ Yes ☐ No
Is this accident / injury covered by Workers' Compensation? ☐ Yes ☐ No
Provide a brief description of the accident.:
There are no Riders attached to this policy.

☐ Diagnostic Test Benefit Rider *(Attach itemized bill for services received.)*
Diagnostic Facility Name _____ Test Date _____

☐ Initial Confinement Benefit Rider

☐ Critical Illness / Specified Disease Rider *(See Certificate of Insurance for eligible conditions. Certificate provided by your Employer. Include any supporting documentation, operative reports or test results.)*

☐ Coma	☐ End Stage Renal Failure	☐ Major Organ Failure	☐ Stroke
☐ Coronary Artery Bypass	☐ Heart Attack	☐ Permanent Paralysis	

Order #167313 (e) 08/01/2016

Employee / Insured Name _____ Group Policy Number 68254-3

SECTION 5. AUTHORIZATION AND ACKNOWLEDGMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

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, MIB, Inc. (MIB), Social Security Administration or employer to give ReliaStar Life Insurance Company (ReliaStar Life) 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 ReliaStar Life to get consumer or investigative consumer reports about me. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about me.

I give my permission to ReliaStar Life 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 ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life 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 ReliaStar Life'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.

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

Employee / Insured 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 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.

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 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil 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.

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

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

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures
For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices
Collecting Information
Your application or claim form is our main source of information. But we may:
- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports
Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.
We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

RESET FORM

AUTHORIZATION TO RELEASE INFORMATION

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Security Life of Denver Insurance Company, Denver, CO
Midwestern United Life Insurance Company, Fort Wayne, IN
Voya Insurance and Annuity Company, Des Moines, IA
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 *(select Contact & Services > Claims Center > Upload a Claim)*

Claim Number _____ Insured / Patient Birth Date _____

Insured / Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Group or Association Name [1] *(if applicable)* State of South Dakota

Group or Association Policy Number [1] 68254-3 **OR** Insurance Policy Number _____

[1] ***Group or Association Name*** *and* ***Group or Association Policy Number*** *apply ONLY if coverage was obtained through an Employer or Association.*

☒ This is an employer-sponsored plan. Please provide employment information as of the date of application.

Employee Name _____

Employer Name STATE OF SOUTH DAKOTA Employer Phone (866) 237-9411

Employer Address 500 E. CAPITOL AVE. City PIERRE State SD ZIP 57501

Use the table below to list:

- the Insured's primary care physician, from _____ to _____
- all hospitals, clinics or institutions where the Insured was treated, from _____ to _____
- all pharmacies where the insured received prescriptions, from _____ to _____

Name	Complete Mailing Address	Phone Number	Fax Number
Patty Jensen or Jamelle Moen	Risty Benefits, Inc. P.O. Box 90335 Sioux Falls, SD 57109-0335	(866) 237-9411	(605) 338-2823

ATTACH ADDITIONAL DOCUMENTS IF MORE SPACE IS NEEDED.
IMPORTANT! SIGNATURE REQUIREMENT ON PAGE 2.

Insured / Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Group or Association Name [1] *(if applicable)* State of South Dakota

Group or Association Policy Number [1] 68254-3 **OR** Insurance Policy Number _____

[1] ***Group or Association Name*** *and* ***Group or Association Policy Number*** *apply ONLY if coverage was obtained through an Employer or Association.*

I authorize release of the following information:

☐ Abstract (The Abstract includes: History & Physical Exams, Operative Reports, Discharge Summaries, EKG/Cardiovascular, Substance Abuse, Mental Health, Emergency Medicine Reports, Office Notes, Consultations/Evaluations, Diagnostic Reports

☐ HIV/AIDS Testing & Treatment ☐ Laboratory Reports ☐ Employment Records ☐ Police and Accident Reports ☐ Medical Examiner/Coroner Reports

☐ Other _____

Collection of Information: In order to evaluate or administer claims for benefits, we must collect information about the insured. The type of information that we may collect includes, but is not limited to, the following examples: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information, including earnings and other employment-related information; accident, incident, or police reports; medical examiner and coroner reports. The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically-related facilities, insurance or reinsuring companies, MIB, Inc., employer or group policy owners, contract holders, benefit plan administrators, and any other organizations.

Acknowledgement: I acknowledge these statements:

- I understand that I may revoke this Authorization at any time by sending a written request to Voya. Such revocation will not have any effect on any action taken by Voya and its' affiliates prior to the revocation.
- This authorization will expire one (1) year from the date of signature or when revoked or on the following date _____.
- I understand that this information may include information relating to: (a) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, (b) Mental or behavioral health or psychiatric care, (c) Treatment of drug or alcohol abuse.
- I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
- This information will be used/disclosed for insurance claim determination.
- I understand that a photocopy of this Authorization will be as valid as the original.

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

Signature _____ Date _____

If signed by someone other than the insured, indicate relationship:

☐ Legal Guardian [2] ☐ Estate Representative [2] ☐ Health Care Power of Attorney [2] ☐ Self ☐ Parent ☐ Spouse ☐ Next of Kin ☐ Beneficiary

☐ Other _____

[2] *If signed by a Legal Representative attach appropriate documentation to verify authority.*