

## DEATH CLAIM FOR ASSOCIATION PLANS

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

ING Life Claims: PO Box 1548, Minneapolis, MN 55440, Toll-Free: 888-238-4840



Complete form and sign the Administrator Certification. The Beneficiary Statement must be signed by the beneficiary if the amount payable to the beneficiary is \$5,000 or more. Forward completed claim form along with a signed W-9 form from each beneficiary, a certified death certificate, application(s) or group enrollment documentation, and any beneficiary changes to the above address.

## GROUP POLICYHOLDER INFORMATION

Plan Name \_\_\_\_\_

Group Policy Number \_\_\_\_\_ Account Number \_\_\_\_\_

## MEMBER INFORMATION

Insured Name \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_

Other names the Insured may have been known by (*maiden name, hyphenated, nickname, derivative of first or middle name, or alias*) \_\_\_\_\_

Address \_\_\_\_\_

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

Marital Status:  Married  Domestic Partner/Civil Union  Never Married  Divorced  Widow(er) Sex:  Male  Female

## CLAIM INFORMATION

Amount of claim

Certificate Number \_\_\_\_\_ Amount \$ \_\_\_\_\_

Effective Date \_\_\_\_\_ Premium Paid to Date \_\_\_\_\_

Certificate Number \_\_\_\_\_ Amount \$ \_\_\_\_\_

Effective Date \_\_\_\_\_ Premium Paid to Date \_\_\_\_\_

Certificate Number \_\_\_\_\_ Amount \$ \_\_\_\_\_

Effective Date \_\_\_\_\_ Premium Paid to Date \_\_\_\_\_

Date of Death \_\_\_\_\_ Cause of Death \_\_\_\_\_

If death was caused by injuries, explain (*Attach newspaper clipping, if available*) \_\_\_\_\_

**If claim is for insurance on a dependent, give the following information concerning dependent (*list life amount above*)**

Relationship to the Insured:  Spouse  Domestic Partner/Civil Union  Child Date this dependent insured \_\_\_\_\_

Name (*please print*) \_\_\_\_\_

SSN \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

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

Marital Status:  Married  Domestic Partner/Civil Union  Never Married  Divorced Sex:  Male  Female

Insured Name \_\_\_\_\_ SSN \_\_\_\_\_ Group Policy Number \_\_\_\_\_

### ADMINISTRATOR CERTIFICATION

The above statements as to the insured are correct as reported on the administrator's records. A Settlement Option Brochure as identified on the Company website, <http://www.ingemployeebenefits-us.com/service/forassociations/formslibrary/index.htm>, has been provided to each beneficiary.

Administrator Name \_\_\_\_\_

Administrator's Address \_\_\_\_\_

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

 Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_

### BENEFICIARY STATEMENT *(Name, Address, Birth Date and Social Security Number of each beneficiary is required.)*

Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_

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

I am making claim for the life insurance proceeds as \_\_\_\_\_ *(Beneficiary, Spouse, Executor, Trustee, etc.)*

*If as trustee, give date the trust was created* \_\_\_\_\_.

 Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

### BENEFICIARY STATEMENT *(Name, Address, Birth Date and Social Security Number of each beneficiary is required.)*

Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_

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

I am making claim for the life insurance proceeds as \_\_\_\_\_ *(Beneficiary, Spouse, Executor, Trustee, etc.)*

*If as trustee, give date the trust was created* \_\_\_\_\_.

 Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

**If needed, please complete additional Beneficiary Statements and attach to this form.**

### FRAUD WARNINGS

**Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, 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.

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**FRAUD WARNINGS (Continued)**

**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.

**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.

**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.

**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.

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**CLAIM CHECKLIST**

- Is the Administrator Certification complete and signed?
- Has each beneficiary signed a Beneficiary Statement?
- Has each beneficiary completed and signed a Form W-9?
- Is the beneficiary designation and enrollment documentation attached?
- Is the death certificate a certified copy that shows manner and cause of death?