Death Claim

ING

Complete and sign the Employer's Statement. The Statement of Beneficiary 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 certified death certificate, a copy of the Insured's enrollment forms, and any beneficiary changes to: *ING Life Claims, P.O. Box 1548, Minneapolis, MN 55440.*

☐ ReliaStar Life Insurance Company
☐ ReliaStar Life Insurance Company of New York (outside NY)
Members of the ING family of companies
Toll-Free: 888-238-4840

Employer's Statement

Insured's Name	Birthdate	Marital Status ☐ Married ☐ Divorced ☐ Never Married ☐ Widow(er)
Other names by which the Insured may be or have been known *(maiden, hyphenated, nickname, derivative of first and/or middle, or alias).*		
Address *(Street, City or Town, State, ZIP)*	Sex ☐ Male ☐ Female	Social Security Number
Policyholder's Name / Group Policy Number	Account Number	Job Title
Amount of this claim Basic $____ Accidental Death $____ Optional $____ Opt. Accidental Death $____ Supplemental $____ Other____ $____	Date first entered employment	Date last worked prior to death
	Salary $____ per ☐ hour ☐ week ☐ month ☐ year	Status ☐ Full-time ☐ Part-time If part-time, average hours per week
Reason for stopping work		
Status of employee at death ☐ Active ☐ Retired ☐ Disability Waiver of Premium		☐ Union ☐ Non Union
Date of Application for coverage / Effective Date of Coverage / Date of last salary change		Date of last beneficiary designation
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):

Name	Address *(Street, City, State, ZIP)*	Social Security Number
Birthdate / Sex ☐ Male ☐ Female	Relationship to Insured ☐ Spouse ☐ Child / Marital Status ☐ Married ☐ Single ☐ Divorced	Date this dependent insured

Employer Certification The above statements as to the insured are correct as reported on the employer's records. A Settlement Option Brochure as identified on the Company website, http://www.ingemployeebenefits-us.com/service/foremployers/formslibrary/death_claims.htm, has been provided to each beneficiary.

Name of Employer	Date *(Month, Day, Year)*
Employer's Address *(Street, City or Town, State, ZIP)*	Telephone Number
Authorized Signature	Title

Statement of Beneficiary *Name, Address, Birthdate, and Social Security Number of each beneficiary is required.*

Name of Beneficiary	Social Security Number	Birthdate	Relationship
Address *(Street, City, State, ZIP)*		Telephone Number	

I certify under penalties of perjury that the Social Security Number on this form is correct. I am not subject to backup withholding. I am making claim for the life insurance proceeds as _____
(Beneficiary, Spouse, Executor, Trustee, etc.)

If as trustee, give date the trust was created _____.
Date

The Internal Revenue Service does not require your consent to any provision of this document other than the certificate required to avoid backup withholding.

Beneficiary Signature X	Date

See reverse side of form for additional Statements of Beneficiary and Fraud Warnings. Page 1 of 2 and page 2 of 2 are required to file a claim.

Statement of Beneficiary *Name, Address, Birthdate, and Social Security Number of each beneficiary is required.*

Name of Beneficiary	Social Security Number	Birthdate	Relationship
Address *(Street, City, State, ZIP)*		Telephone Number	

I certify under penalties of perjury that the Social Security number on this form is correct. I am not subject to backup withholding. I am making claim for the life insurance proceeds as _____
(Beneficiary, Spouse, Executor, Trustee, etc.)

If as trustee, give date the trust was created _____.
Date

The Internal Revenue Service does not require your consent to any provision of this document other than the certificate required to avoid backup withholding.

Beneficiary Signature X	Date

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

Fraud Warnings

Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, 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.

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.

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.