RESET FORM

CHANGE REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
Customer Service: PO Box 20, Minneapolis, MN 55440
Phone: 877-236-7564

Instructions

Employee: Complete form and sign as required below. Return this form to your employer. If you have an individual life policy (Whole Life, Universal Life, Portable Term Life) or, if you pay premium directly to the Company, then contact Voya at the number above.

Employer: Process the change(s) as necessary. Place the original in the employee's permanent file. Not to be used to change ownership of Life Insurance.

PLAN INFORMATION

Group Number _____ Account Number _____

EMPLOYEE INFORMATION

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____ Phone (_____)_____

Address _____

City _____ State _____ ZIP _____

OWNER INFORMATION *(If ownership of Life Insurance was assigned)*

Owner Name _____

Birth Date _____ SSN/TIN _____ Phone (_____)_____

Address _____

City _____ State _____ ZIP _____

NAME/CONTACT CHANGES

☐ Change legal name of: ☐ Employee ☐ Owner

Previous Name _____

New Name _____

Reason for Change *(If court order, attach copy.)* _____

☐ Change Contact Information to:

Address _____

City _____ State _____ ZIP _____

Birth Date _____ SSN _____ Phone (_____)_____

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Group Number _____ Account Number _____

REDUCTIONS OR CANCELLATIONS OF EMPLOYEE PAID COVERAGE

(Check with your employer to detemine what coverage you have and what changes can be made. IF YOU NEED TO MAKE CHANGES TO MORE THAN ONE TYPE OF COVERAGE, COMPLETE SEPARATE FORMS.)

Note: Changes will be effective the first of the month following receipt of form.

The change applies to the following coverage *(Select only one.)*:

☐ Term Life
☐ AD&D
☐ Short Term Disability Income
☐ Long Term Disability Income
☐ Accident
☐ Critical Illness/Specified Disease
☐ Hospital Confinement Indemnity

Coverage Reduction

☐ Reduce Employee Basic coverage: Effective Date _____

☐ by one level ☐ from $_____ to $_____ ☐ Other _____

☐ Reduce Employee Supplemental coverage: Effective Date _____

☐ by one level ☐ from $_____ to $_____ ☐ Other _____

☐ Reduce Spouse coverage: Effective Date _____

☐ by one level ☐ from $_____ to $_____ ☐ Other _____

☐ Reduce Children coverage: Effective Date _____

☐ by one level ☐ from $_____ to $_____ ☐ Other _____

Coverage Cancellation

Note: In order to continue dependent coverage, employee must continue supplemental coverage.

☐ Cancel Employee Basic coverage: Effective Date _____

☐ Cancel Employee Supplemental coverage: Effective Date _____

☐ Cancel Spouse coverage: Effective Date _____

☐ Cancel Children coverage: Effective Date _____

Date youngest child reached the maximum age, if applicable. *(Attach copy of birth certificate.)* _____

AUTHORIZATIONS

Employee Signature *(Required.)* _____ Date _____

Owner Signature *(If ownership of Life Insurance was assigned.)* _____ Date _____

EMPLOYER / PLAN ADMINISTRATOR USE ONLY

Date Received _____ Date Processed _____ Processed By _____