

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

ReliaStar Life Insurance Company, Minneapolis, MN  
ReliaStar Life Insurance Company of New York, Woodbury, NY  
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Phone: 877-236-7564

Voya Claims: PO Box 320, Minneapolis, MN 55440; Overnight Address: 20 Washington Ave. South, Minneapolis, MN 55401

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 can be obtained from the Employer / Administrator.)

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

## SECTION 2. EMPLOYEE / INSURED / MEMBER INFORMATION

Select, if applicable.:  International / Foreign Address

Patient Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

Patient Birth Date \_\_\_\_\_ Patient Phone (\_\_\_\_\_) \_\_\_\_\_ International Phone \_\_\_\_\_

Employee / Member Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province / State \_\_\_\_\_ ZIP \_\_\_\_\_

Country \_\_\_\_\_

## 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. If the patient does not have one of the specific illnesses listed below, the claim may not be eligible.)

### Aneurysms:

Abdominal Aortic Aneurysm

Has the patient been diagnosed with an enlargement of the abdominal aorta of 5 cm or more, or of 4 cm or greater and rapidly expanding in which surgical repair has been advised? (Attach test results.) . . . . .  Yes  No

Ruptured or Dissecting Aneurysm (Aneurysms of the arm or leg are not considered a Ruptured or Dissecting Aneurysm.)

Has the patient been diagnosed with a balloon-like bulge in an artery that ruptures or dissects as confirmed by an ultrasound, CT scan, angiogram or MRI? (Attach test results.) . . . . .  Yes  No

Thoracic Aortic Aneurysm

Has the patient been diagnosed with an enlargement of the thoracic aorta of 5.5 cm or more, or causing symptoms, or of 4.5 cm or greater and rapidly expanding in which surgical repair has been advised? (Attach test results.) . . . . .  Yes  No

Group / Association Policy Number \_\_\_\_\_

Patient Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

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

**Cancers:**

Initial Diagnosis Date \_\_\_\_\_ Any Subsequent Diagnosis Dates \_\_\_\_\_

**Benign Brain Tumor**  
Has a biopsy been performed to confirm diagnosis? . . . . .  Yes  No

Type of Tumor (Attach test results.) \_\_\_\_\_

**Bone Marrow Transplant**  
Has the patient undergone a bone marrow transplant? . . . . .  Yes  No

If the transplant has not been performed, is the patient on the Be the Match registry? . . . . .  Yes  No

**Cancer/Carcinoma in Situ**  
Cancer/Carcinoma in Situ was diagnosed using:  Pathological Diagnosis (Attach copy of report)  Clinical Diagnosis (Provide reason for not obtaining pathological diagnosis and attach medical evidence that supports the diagnosis of cancer.)

Stage of Cancer \_\_\_\_\_

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

**Stem Cell Transplant**  
Has or will the patient undergo a surgical stem cell transplant? (Attach test results.) . . . . .  Yes  No

**Endocrine Conditions:**

**Addison's Disease**  
Diagnosis confirmed by (Attach test results.):  Blood test  Urine test  Medical imaging

**Type 1 Diabetes**  
Was diagnosis based on blood tests? (Attach test results) . . . . .  Yes  No

How long has patient been insulin dependent? \_\_\_\_\_

What is the start date of treatment? \_\_\_\_\_

**Heart/Cardiac Conditions:**

Procedure Date \_\_\_\_\_

**Coronary Angioplasty**  
Did or will the patient undergo a  Coronary balloon angioplasty  Angiojet clot removal  
 Rotational and orbital atherectomy procedure (Attach operative report.)

**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

**Heart Attack (A sudden cardiac arrest is not in itself considered a 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

**Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement**  
Has the patient undergone or been advised to undergo an initial placement of an implantable cardioverter-defibrillator (ICD)? (Attach operative results.) . . . . .  Yes  No

**Open Heart Surgery for Valve Replacement or Repair**  
Has the patient undergone or been advised to undergo open heart surgery to repair one or more valves due to severe valvular heart disease? (Attach operative report.) . . . . .  Yes  No

Group / Association Policy Number \_\_\_\_\_

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

- Pacemaker Placement**  
Has the patient undergone or been advised to undergo an initial placement of a permanent pacemaker?  
(Attach operative report.) . . . . .  Yes  No
- Sudden Cardiac Arrest**  
Has the patient had a sudden, unexpected loss of heart function, breathing, or consciousness due to an internal electrical disturbance of the heart?  
(Attach test results.) . . . . .  Yes  No  
Did the sudden cardiac arrest result in death? (Attach autopsy report or death certificate.) . . . . .  Yes  No
- Transcatheter Heart Valve Replacement or Repair**  
Has the patient undergone or been advised to undergo a procedure performed through the blood vessels to replace or repair one or more heart valves? (Attach operative report.) . . . . .  Yes  No

**Neurological Conditions:**

- Advanced Dementia, including Alzheimer's Disease**  
The patient is UNABLE to perform 2 or more Activities of Daily Living (see definitions below.) . . . . .  Yes  No  
ACTIVITIES OF DAILY LIVING: The basic human functional abilities required for the Insured to remain independent:
  - Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
  - Contenance: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including catheter or colostomy bag).
  - Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
  - Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
  - Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
  - Transferring: Moving into or out of bed, chair, or wheelchair.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
- 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
- Huntington's Disease (Huntington's Chorea)**  
Does the patient display symptoms of Huntington's Disease? (Attach lab testing.) . . . . .  Yes  No
- Multiple Sclerosis**  
Are symptoms persistent for 6 or more months? (Attach MRI and spinal fluid analysis.) . . . . .  Yes  No
- Muscular Dystrophy**  
Diagnosis established by (Attach test results.):  Muscle biopsy  Increased creatine Phosphokinase (CpK3)  Electromyography
- Myasthenia Gravis**  
Diagnosis established by (Attach test results.):  Neurological exam  Edrophonium test  EMG  
 CT Scan  MRI  Blood analysis  Repetitive nerve stimulation
- 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? . . . . .  Yes  No  
Cause of Paralysis \_\_\_\_\_

Group / Association Policy Number \_\_\_\_\_

Patient Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

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

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 or 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

Did the patient experience any neurological impairment since discharged from the hospital? . . . . .  Yes  No

Transient Ischemic Attacks (TIA)

Was the transient episode of neurologic dysfunction caused by focal brain, spinal cord or retinal ischemia, without acute infarction? (Attach copies of any applicable reports.) . . . . .  Yes  No

**Rheumatologic Conditions:**

Systemic Lupus Erythematosus (SLE)

Diagnosis established by (Attach test results.):  Blood analysis  Diagnostic criteria (Provide reason for not obtaining laboratory tests and attach medical evidence that supports the diagnosis of SLE.)

Systemic Sclerosis (Scleroderma)

Was the patient diagnosed with an autoimmune disease that involves the hardening and tightening of the skin and connective tissues? (Attach test results.) . . . . .  Yes  No

**Other Conditions:**

End Stage Renal (Kidney) Failure (See Major Organ Transplant or Major Organ Failure below)

Infectious Disease

Was patient confined to a  Hospital  Transitional Care Facility  
If "yes," how many consecutive days in the hospital or transitional care facility? \_\_\_\_\_

Define the type of infectious disease (Attach lab test results.) \_\_\_\_\_

Loss of Hearing/Deafness

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

Loss of Sight/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 irrecoverably reduced to 20/200 or less in the better eye? \_\_\_\_\_  O.D.  O.S.

Loss of Speech

Was patient diagnosed with total and permanent loss of the ability to speak? (Attach copy of report.) . . . . .  Yes  No

Major Organ Transplant or 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 United Network for Organ Sharing (UNOS) list for transplant? . . . . .  Yes  No

Date Added to the UNOS List \_\_\_\_\_ Date Diagnosed with Organ Failure \_\_\_\_\_

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

If end stage renal (kidney) failure, 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

On what date did dialysis treatments begin? \_\_\_\_\_

Occupational Hepatitis B or C

Did the patient contract Hepatitis B or C 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

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

Group / Association Policy Number \_\_\_\_\_

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

- Severe Burns  
Is the burn over more than 35 square inches? . . . . .  Yes  No  
Is the burn full thickness or 3rd degree? (Attach copies of any applicable reports.) . . . . .  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
- Gaucher Disease, Type II or III  
Was a definitive diagnosis confirmed through a blood test reviewing beta-glucosidase leukocyte (BGL)?  
(Attach test results.) . . . . .  Yes  No
- Infantile Tay Sachs  
Was a definitive diagnosis confirmed through a blood test reviewing Hexosaminidase A levels? (Attach test results.) . . . . .  Yes  No
- Niemann-Pick Disease  
Diagnosis established by (Attach test results.):  Blood test  Genetic test  
Classification:  Type A  Type B  Type C
- Pompe Disease (Type II Glycogen Storage Disease)  
Diagnosis established by (Attach test results.):  Enzyme Test  Genetic test
- Sickle Cell Anemia  
Was the diagnosis confirmed through a blood test? (Attach test results.) . . . . .  Yes  No
- Type 1 Diabetes (See Endocrine Conditions section above)
- Type IV Glycogen Storage Disease  
Diagnosis established by (Attach test results.):  Enzyme Test  Genetic test
- Zellweger Syndrome  
Was a definitive diagnosis confirmed through genetic testing? (Attach test results.) . . . . .  Yes  No

Group / Association Policy Number \_\_\_\_\_

Patient Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

## 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 \_\_\_\_\_ 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.