AFFIDAVIT ABOUT HEIRS OF DECEDENT INCLUDING SIBLINGS

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440
Voya Life Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis MN 55401
Phone: 888-238-4840; Fax: 855-653-5339
Submit at voya.com (select Contact & Services > Claims > Upload a Claim)

INSTRUCTIONS

- All surviving heirs should be listed on ONE form. Only ONE person/heir must sign the form but the names of all heirs must be included on the form.
- Upon completion of this form the Company will pay the claim in this order: Spouse, Children (biological or adopted - does not include stepchildren), Parents and Siblings. If there are no heirs that can be listed on this form, the life insurance benefit will be paid to the estate of the insured.
- A Claimant's Statement must be completed and signed by each heir who will be receiving a benefit.
- This form must be notarized.

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

Group/Association Name ______________________________

Group/Association Policy Number ____________________ Account Number ____________________

SECTION 2. EMPLOYEE / INSURED / MEMBER INFORMATION

Employee / Insured / Member Name *(First)* ____________________ *(Middle Initial)* ____ *(Last)* ____________________

Birth Date ____________________ SSN ____________________ Gender: ☐ Male ☐ Female

Address ____________________ City ____________________ State ________ ZIP ________

Employee / Insured / Member Date of Death ____________________ Employee / Insured / Member State of Residence ____________________

SECTION 3. HEIRS INFORMATION

The following relatives of the insured were **living at the time of the insured's death**, and are the only heirs-at-law who could claim an interest in the insured's estate:

The Heirs (listed below) are: ☐ Spouse of Insured ☐ Child(ren) of Insured ☐ Parent(s) of Insured ☐ Sibling(s) of Insured

Spouse of the Insured Name *(First)* ____________________ *(Middle Initial)* ____ *(Last)* ____________________

Birth Date ____________________ SSN ____________________ Phone (______)____________________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ____________________

Address ____________________ City ____________________ State ________ ZIP ________

Child of the Insured Name *(First)* ____________________ *(Middle Initial)* ____ *(Last)* ____________________

Birth Date ____________________ SSN ____________________ Phone (______)____________________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ____________________

Address ____________________ City ____________________ State ________ ZIP ________

Child of the Insured Name *(First)* ____________________ *(Middle Initial)* ____ *(Last)* ____________________

Birth Date ____________________ SSN ____________________ Phone (______)____________________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ____________________

Address ____________________ City ____________________ State ________ ZIP ________

Child of the Insured Name *(First)* ____________________ *(Middle Initial)* ____ *(Last)* ____________________

Birth Date ____________________ SSN ____________________ Phone (______)____________________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ____________________

Address ____________________ City ____________________ State ________ ZIP ________

Employee / Insured / Member Name ______________________ Group/Association Policy Number ______________

SECTION 3. HEIRS INFORMATION *(Continued)*

Child of the Insured Name *(First)* ______________ *(Middle Initial)* ____ *(Last)* ______________

Birth Date ____________ SSN ______________ Phone (______)____________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ______________

Address ______________________ City ______________ State ________ ZIP ________

Child of the Insured Name *(First)* ______________ *(Middle Initial)* ____ *(Last)* ______________

Birth Date ____________ SSN ______________ Phone (______)____________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ______________

Address ______________________ City ______________ State ________ ZIP ________

Parent of the Insured Name *(First)* ______________ *(Middle Initial)* ____ *(Last)* ______________

Birth Date ____________ SSN ______________ Phone (______)____________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ______________

Address ______________________ City ______________ State ________ ZIP ________

Parent of the Insured Name *(First)* ______________ *(Middle Initial)* ____ *(Last)* ______________

Birth Date ____________ SSN ______________ Phone (______)____________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ______________

Address ______________________ City ______________ State ________ ZIP ________

Sibling of the Insured Name *(First)* ______________ *(Middle Initial)* ____ *(Last)* ______________

Birth Date ____________ SSN ______________ Phone (______)____________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ______________

Address ______________________ City ______________ State ________ ZIP ________

Sibling of the Insured Name *(First)* ______________ *(Middle Initial)* ____ *(Last)* ______________

Birth Date ____________ SSN ______________ Phone (______)____________ Gender: ☐ Male ☐ Female

Deceased: ☐ Yes ☐ No If Deceased, provide Date of Death. ______________

Address ______________________ City ______________ State ________ ZIP ________

SECTION 4. AUTHORIZATION

I hereby agree to indemnify and hold harmless the above Company from any and all costs, reasonable attorney's fees, actions, loss or damage which it may suffer by virtue of payment to me (us) under and because of said policy/policies of insurance.

If there are no surviving eligible heirs listed above, please contact our Claims Department at 888-238-4840.

Authorized Signature ______________________ Date ______________

Subscribed and sworn before me this ______________ day of ______________, 20______

Notary Public ______________________

My Commission Expires ______________________