RESET FORM

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Security Life of Denver Insurance Company, Denver, CO
Midwestern United Life Insurance Company, Fort Wayne, IN
Voya Insurance and Annuity Company, Des Moines, IA
Members of the Voya® family of companies
(the "Company")

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO:

- ☐ Voya Insurance and Annuity Company
- ☐ Midwestern United Life Insurance Company
- ☐ ReliaStar Life Insurance Company
- ☐ ReliaStar Life Insurance Company of New York
- ☐ Security Life of Denver Insurance Company

This authorization complies with the HIPAA Privacy Rule.

Insured / Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Insured / Patient Birth Date _____

Group or Association Name [1] *(if applicable)* _____

Group or Association Policy Number [1] _____ **OR** Insurance Policy Number _____

[1] ***Group or Association Name*** *and* ***Group or Association Policy Number*** *apply ONLY if coverage was obtained through an Employer or Association.*

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, medical facility, or other health care provider that has provided payment, treatment or services to Patient or on Patient's behalf within the past 10 years, unless otherwise provided by state law, ("Providers") to disclose Patient's entire medical record and any other protected health information concerning Patient to the Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict Patient's protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose Patient's entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite Patient's application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage Patient has or has applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 20 Washington Avenue South, Minneapolis, MN 55401, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any Providers have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed, including the reporting of protected health information or personally identifiable information to MIB, Inc., and is no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by any applicable state privacy laws, state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that the signing of this authorization is not a condition for obtaining treatment or payment for services. I further understand that if I refuse to sign this authorization to release Patient's complete medical record, the Company may not be able to process Patient's application, or if coverage has been issued may not be able to make a claim determination. I acknowledge that I have received a copy of this authorization.

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

Patient or
Personal Representative Signature _____ Date _____

Description of Personal Representative's
Authority or Relationship to Patient _____

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