

DEATH CLAIM

- ReliaStar Life Insurance Company, Minneapolis, MN
 ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)

A member of the ING family of companies
 ("the Company")

ING Life Claims: PO Box 1548, Minneapolis, MN 55440, Toll-Free: 888-238-4840

ING Life Claims Overnight Mailing Address: 20 Washington Ave. So, Minneapolis, MN 55401



The Group Policyholder Information, Employee Information, Claim Information and Employer Certification sections must be completed by the employer. The Beneficiary statement must be completed and signed by the beneficiary. Forward the claim form, a certified death certificate, a copy of the Insured's enrollment documentation, and any beneficiary changes to the above address.

CLAIM CHECKLIST

- Is the Employer Certification complete and signed?
 Has each beneficiary signed a Beneficiary Statement?
 Is the beneficiary designation and enrollment documentation attached?
 Is the death certificate a certified copy that shows manner and cause of death?

GROUP POLICYHOLDER INFORMATION

Group Policyholder _____

Group Policy Number _____ Account Number _____

EMPLOYEE INFORMATION

Insured Name _____

Birth Date _____ SSN _____

Other Names the Insured May Have Been Known By (*maiden name, hyphenated, nickname, derivative of first or middle name, or alias*):

Address _____

City _____ State _____ ZIP _____

Marital Status: Married Domestic Partner/Civil Union Never Married Divorced Widow(er) Gender: Male Female

Employment Start Date _____

Date Last Actively at Work Prior to Death (*also include for dependent claims*) _____

Job Title _____

Salary \$ _____ per: hour week month year Last Salary Change Date _____

Employment Status: Full Time Part Time Average hours per week _____ Union Non Union

Status of employee at death: Active Retired Disability Waiver of Premium FMLA (*include FMLA documentation*)

Reason for Stopping Work _____

Have premiums been paid to the date of death? Yes No If "No," to what date have premiums been paid? _____

CLAIM INFORMATION

Basic Life \$ _____ Accidental Death \$ _____ Effective Date _____

Supplemental Life \$ _____ Supplemental Accidental Death \$ _____ Effective Date _____

Optional Life \$ _____ Effective Date _____

Other \$ _____ Effective Date _____

Date of Death _____ Cause of Death _____

If death was caused by injuries, explain (*Attach newspaper clipping, if available*) _____

Insured Name _____ SSN _____ Group Policy Number _____

CLAIM INFORMATION (Continued)

If claim is for insurance on a dependent, give the following information concerning dependent (*list life amount on page 1*).

Relationship to the Insured: Spouse Domestic Partner/Civil Union Child Date This Dependent Insured _____

Name (*please print*) _____

Birth Date _____ SSN _____

Address _____

City _____ State _____ ZIP _____

Marital Status: Married Domestic Partner/Civil Union Never Married Divorced Gender: Male Female

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 web site, <http://www.ing-usa.com/us/businesses/employeebenefits/formslibrary/deathclaims/index.htm>, has been provided to each beneficiary. (*See page 3 for fraud warnings.*)

Employer Name _____

Employer Address _____

City _____ State _____ ZIP _____

 Authorized Signature _____ Date _____

Title _____ Phone (_____) _____ E-mail _____

BENEFICIARY STATEMENT (Name, Address, Birth Date and Social Security Number of each beneficiary is required. (See page 3 for fraud warnings.))

Tax Residency Information (Required)

Check one of the three boxes:

U.S. Citizen

U.S. Resident Alien

Non-Resident Alien. Non-resident aliens must indicate your non-U.S. country of tax residency _____.

If you do not have a U.S. Social Security Number, you must apply for and receive an Individual Taxpayer Identification Number from the Internal Revenue Service (IRS) or a U.S. Embassy by using IRS Form W-7 (Application for IRS Individual Taxpayer Identification Number) which is available on the IRS web site: www.irs.gov or by contacting the IRS at 800-829-1040. Since you are not a U.S. person, any taxable portion is subject to 30% withholding provisions for non-resident aliens unless tax treaty provisions can be applied. If you want to invoke a tax treaty, you must complete, sign and date, and return to us the IRS Original Form W-8BEN, "Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding."

Taxpayer Certification

Under penalties of perjury, I certify that:

1. The number on this form is my correct taxpayer identification number; and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (including U.S. resident alien) as defined by the IRS.
 I am a non-resident alien and the Taxpayer Certification language included in this form does not apply to me.

The obligation of the insurer to pay the total policy or contract proceeds is satisfied by depositing the total proceeds in a retained asset account.

Beneficiary Name _____ Relationship _____

Birth Date _____ SSN _____

Phone (_____) _____ E-mail _____

Address _____

City _____ State _____ ZIP _____

I am making claim for the life insurance proceeds as (*Beneficiary, Spouse, Executor, Trustee, etc.*) _____

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

 Beneficiary Signature _____ Date _____

If there is more than one beneficiary, please complete additional Beneficiary Statements and attach to this form.

FRAUD WARNINGS

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

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.

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.