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

Instructions:

Employee: Complete form and sign as required below. Return this form to your employer.

Employer: Process the change(s), as necessary. Place the original in the employee's permanent file.

INSURED INFORMATION

Insured Name *(Last, First, MI)* ______________________________

Birth Date ______________ SSN ______________ Phone (____) ______________

Address ______________________ City ______________ State ________ ZIP ________

Plan Number ______________________ Account Number ______________________

Policy / Certificate Number ______________________________

OWNER INFORMATION

Owner Name ______________________________

Birth Date ______________ SSN ______________ Phone (____) ______________

Address ______________________ City ______________ State ________ ZIP ________

POLICY CHANGES

☐ Change name of: ☐ Insured ☐ 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 (____) ______________

☐ Issue duplicate policy / certificate

COVERAGE REDUCTION

☐ Reduce employee coverage from $______________ to $______________ Effective Date ______________

☐ Reduce spouse coverage from $______________ to $______________ Effective Date ______________

☐ Reduce children's coverage from $______________ to $______________ Effective Date ______________

COVERAGE CANCELLATIONS

☐ Cancel policy / certificate effective *(month, day, year)* ______________________________

☐ Cancel spouse coverage effective *(month, day, year)* ______________________________

☐ Cancel children's coverage effective *(month, day, year)* ______________________________

☐ Youngest child reached maximum age (see policy) *(month, day, year)* ______________ *Attach a copy of birth certificate.*

Employee Signature *(required)* ______________________________ Date ______________

Spouse Signature *(if change affecting spouse coverage)* ______________________________ Date ______________

Employer / Plan Administrator ______________________________ Date ______________

EMPLOYER / PLAN ADMINISTRATOR USE ONLY

Date Received ______________ Date Processed ______________ Processed By ______________________