RESET FORM

PAYROLL DEDUCTION REQUEST FOR SERVICE

ReliaStar Life Insurance Company, Minneapolis, MN
(the "Company")
Administrative Office: PO Box 122, Minneapolis, MN 55440-0122
Mail to: Voya Employee Benefits Payroll Deduction Service Center
Attention Customer Service,
PO Box 122
Minneapolis, MN 55440-9181
or Fax to: 1-855-341-4471

VOYA FINANCIAL™

Policy Number _____ **Insured Name** _____

Owner Name ***(If other than Insured)*** _____

1. CHANGE OF BENEFICIARY

It is hereby requested that the beneficiary under the above numbered policy be changed as follows:

Primary Beneficiary *(Please print.)* _____ Relationship to Insured _____

Birth Date _____ SSN _____ Phone (_____)_____

Address _____ City _____ State _____ ZIP _____

Contingent Beneficiary *(Please print.)* _____ Relationship to Insured _____

Birth Date _____ SSN _____ Phone (_____)_____

Address _____ City _____ State _____ ZIP _____

2. CHANGE OF NAME *(If reason is other than marriage or divorce, attach copy of legal evidence.)*

☐ Insured ☐ Owner ☐ Payor ☐ Other *(specify)* _____ Reason _____

Former Name _____ New Name _____

3. CHANGE OF MAILING ADDRESS AND/OR PHONE NUMBER

Former Address _____ City _____ State _____ ZIP _____

New Address _____ City _____ State _____ ZIP _____

Former Phone Number (_____)_____ New Phone Number (_____)_____

4. CHANGE MODE OF PAYMENT OF PREMIUM

Change to: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Checking Account Deduction ☐ Return to Payroll Deduction

5. POLICY LOAN REQUEST *(This change will be effective as of the date the loan request is signed, but it will not apply to any payment made or action taken before this form is recorded at the Company's Administrative Office.)*

Amount Requested: ☐ Maximum Loan ☐ Net Loan of $ _____

This request may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the Policy from which the values are released.

6. REQUEST FOR DUPLICATE POLICY

I, _____ hereby certify that Policy/Certificate Number _____, dated _____, and issued by the Company has been lost or destroyed and that said policy/certificate is not assigned, hypothecated, or pledged in any way whatsoever. I therefore request a replacement policy/certificate and agree that if the original policy/certificate be found or in any way come into my possession, that I will return it or cause the same to be returned to the Company, or its affiliates, its successors, or assigns. It is distinctly understood and agreed that the original policy/certificate shall become null and void immediately upon issuance of the replacement policy/certificate herein requested. A $25.00 fee may be applicable for this request.

7. US TAXPAYER CERTIFICATION

Under penalties of perjury, I certify that:

1. **The Taxpayer Identification Number that appears on this form is correct,**
2. **I am not subject to backup withholding due to failure to report interest and dividend income[1], and**
3. **I am a U.S. person.**

[1]If you are subject to back-up withholding, you must strike through statement number 2.

NON-RESIDENT ALIEN STATUS

If you are a Non-Resident Alien, please check the box below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien.

The amount paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable US tax treaty.

SIGNATURE AUTHORIZATION

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

➥ Current Owner Signature _____ Date _____

Address _____ City _____ State _____ ZIP _____

➥ Irrevocable Beneficiary Signature *(if any)* _____ Date _____

If policy has been assigned, Assignee must also sign the form.

➥ Assignee Signature *(if applicable)* _____ Date _____

FOR COMPANY USE ONLY

This change has been recorded by the Company at its Administrative Office, and any provisions in the policy requiring endorsement by the Company are hereby waived.

By _____ Date _____