AUTHORIZATION TO RELEASE 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
☐ ING USA Annuity and Life Insurance Company, Des Moines, IA
A member of the ING family of companies
(the "Company")
ING Life Claims: P.O. Box 1548, Minneapolis, MN 55440
Toll-Free: 888-238-4840

Insured/Claimant Name _____ Policy # _____

For employer-sponsored plans, please provide us with employment information as of *(date)* _____

Employee Name _____

Employer Name _____ Employer Phone _____

Employer Address _____

List all physicians who attended to the individual and all hospitals or institutions where the individual was treated between the dates listed below. Also list the primary care physician and the individual's pharmacy. *(Attach additional sheets if needed.)*

Starting Date _____ Ending Date _____

Name & Phone #	Complete Mailing Address	Dates Attended	Disease or Condition

☑ History and Physical Exams
☑ Office Notes
☑ Consultations/Evaluations
☑ Diagnostic Reports
☑ Laboratory Reports
☑ Emergency Medicing Reports
☑ Operative Reports
☑ Discharge Summaries
☑ EKG/Cardiovascular
☑ Pulmonary Function Test
☑ Substance Abuse
☑ Mental Health
☑ HIV/AIDS Testing/Treatment
☐ Employment
☐ Police/Accident Reports

☐ Other _____

Collection of Information: In order to evaluate or administer claims for benefits, we must collect information about the insured. The type of information that we may collect includes, but is not limited to, the following examples: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; earnings and other employment-related information; accident, incident, or police reports; any additional non-medical information. The sources that we may contact for information includes, but is not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically related facilities, insurance or reinsuring companies, Medical Information Bureau, Inc. ("MIB"), employer or group policy owners, contract holders, benefit plan administrators, any other organizations.

Federal Regulations - 42CFR Part 2: The insured's medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. If information is protected by federal or state law, you may revoke this authorization at any time by mailing a written request to us at our address listed on the Consumer Privacy Notice. A written request, however, will not apply to any information collected before the date that we receive your request.

Acknowledgement and Statements of Understanding: I understand that this authorization will be valid for the duration of the claim for benefits. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original. I authorize the Company or its affiliates or authorized representatives to collect any of the information listed above to evaluate or administer claims for benefits. I authorize all of the sources listed above to release to the Company or its affiliates or authorized representatives all requested information on the insured. I authorize the Company to send any information obtained to its affiliates, MIB Group, Inc., reinsurers, or employees or contractors who process transactions regarding this claim for benefits. I understand that my additional written consent will be required before any information described above is given, sold, or transferred to another party not specified (unless otherwise provided by law). My additional consent will be required on a form that states the new use of the information or the reason another party needs it. I acknowledge receipt of the following notices: Notice Regarding Consumer Reports, Notice Regarding MIB, Notice Regarding Information Practices.

X Signature of Insured/Claimant _____ Date _____

Indicate relationship if signed by someone
other than the individual named above _____