

APPLICATION INSTRUCTIONS

FICPA MEMBER GROUP TERM LIFE INSURANCE PLAN

1. COMPLETE APPLICATION FORM

Make sure to complete the form in its entirety. Incomplete applications will not be accepted. Illegible print may delay processing of application.

2. COMPLETE PAYMENT METHOD

Payment Option 1 - Monthly Auto Pay

If you elect to pay by Monthly Bank Draft (ACH), you do not need to send any premium. Upon approval of your application by the insurer, we will automatically draft your account on a monthly basis. Make sure to complete the Authorization section and include a VOIDED check.

Payment Option 2 - Direct Annual Billing

If you elect the Direct Annual Billing method, upon approval of your application by the insurer, you will receive an initial invoice for the amount of premium due to pay your coverage through the end of the plan year (to December 31st.)

You will receive annual invoices thereafter, which will be due on January 1st.

3. FAX OR MAIL FORMS TO:

You may use this form as a FAX COVER

Fax to: (904) 396-2091

Your Name: _____ Date: _____

Attn: Application/Processing

Or Mail to:

Program Administrator
Member Benefits
7645 Gate Parkway, Suite 101
Jacksonville, FL 32256

ANY QUESTIONS? CALL TOLL-FREE: 1-800-282-8626

SATISFACTION GUARANTEED. YOU RISK NOTHING BY APPLYING NOW.

If you are not completely satisfied when you receive your Certificate of Insurance, just notify us within 30 days and we'll refund any premium you've paid, provided no claims have been submitted or paid. No insurance will be in force, and you will be under no further obligation.

MEMBER GROUP LEVEL TERM-LIFE INSURANCE PLAN FOR MEMBERS OF FICPA



UP TO
\$1,000,000 IN
COVERAGE

COMPETITIVE
GROUP
RATES

UNDERWRITTEN BY RELIASTAR LIFE INSURANCE
COMPANY, A MEMBER OF THE VOYA® FAMILY OF
COMPANIES, RATED "A" (EXCELLENT) BY A.M. BEST**

COVERAGE FOR SPOUSE, DOMESTIC PARTNER AND CHILDREN

If you are covered in this plan, your spouse or domestic partner is eligible to apply for up to 100% of your coverage amount. If you are a current member and your spouse is under age 66, able to conduct the normal activities of a person of like age and gender, and is in good health simply visit www.memberbenefits.com/floridabar to apply.

Child coverage of \$10,000 is also available. One premium provides \$10,000 of life insurance for all of your eligible unmarried dependent children, ages 6 months to 21 years, or to age 25 if a full-time student. Children ages 14 days to 6 months are eligible for \$1,000 of coverage.

EXCLUSIONS

The only exclusion under this group term life policy is for suicide within the first two years of coverage or an increase in coverage. The optional Accelerated Life Benefit and AD&D benefit are subject to additional exclusions.

PROGRAM ADMINISTRATOR

For all inquiries, contact your program administrator: Member Benefits, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256. 1-800-282-8626.

DESIGNATE YOUR BENEFICIARY

You may designate one or more beneficiaries on the application form. Attach a separate sheet if needed. You may request to change your beneficiary at any time by contacting the plan administrator.

ORGANIZATION BEHIND THE COVERAGE**

Insurance underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. ReliaStar Life Insurance Company is rated "A" (Excellent) by A.M. Best. This is third highest of 15 ratings. A.M.

Best Company assigns ratings from A++ to F based on a company's financial strength and ability to meet obligations to contract holders.

ADMINISTERED BY:

MB | MemberBenefits

VOYA
FINANCIAL

Policy Form LP08GP (product availability and plan provisions may vary by state).

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern.

* The initial premium will not change during your level term period, unless the insurance company exercises its right to change the premium rates for all insureds covered under the group policy and with 60 days advance written notice. To keep coverage in force, premiums are payable up to the date of the group policy or coverage termination.

** Insurance underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy Form LP08GP (product availability and plan provisions may vary by state).

KEEP UP WITH YOUR FAMILY'S FINANCIAL NEEDS WITH UP TO \$1,000,000 IN GROUP TERM LIFE INSURANCE COVERAGE

UP TO \$1,000,000 IN LEVEL TERM PROTECTION AT GROUP RATES DESIGNED TO REMAIN LEVEL FOR 10 YEARS*

This plan is designed to provide an affordable way to update your family's financial security. As long as you are a current member of FICPA, under age 66, and actively working at least 30 hours per week, you may apply for up to \$1,000,000 of level term life insurance.

There are no investment structures, application fees, or annual policy fees, which can inflate cost, and because it's a Level Term Plan, your premiums are based on your age when you apply. Your rate is designed to not increase during the level term period*, regardless of changes in your health. This helps to make the plan a better value over time.

THE APPLICATION PROCESS

Fully complete all sections of the enclosed application and return to the program administrator. Providing complete and accurate information on your application can make the medical underwriting process quicker and easier.

All coverage is subject to underwriting approval by ReliaStar Life Insurance Company, and more medical information may be requested from you or from your attending physician(s). A physical exam, EKG, blood test or other information may also be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. These requirements will be at no cost to you. Acceptance into the life plan is not guaranteed.

COVERAGE EFFECTIVE DATE

Your coverage will become effective on the first of the month following approval of your application by ReliaStar Life, and once your first premium payment is made.

A PAY-OUT FOR TERMINAL ILLNESS OF UP TO \$75,000

If you are terminally ill and have a life expectancy of six months or less, you can receive a portion of your death benefit before dying. This is called the accelerated life benefit. You can receive a payment of 50 percent of your coverage, to a maximum of \$75,000. All remaining insurance benefits will be paid to your beneficiary when you die. This accelerated payment could provide much needed financial relief during a terminal illness when extra funds are needed. The accelerated benefits may be taxable. You should consult a professional tax advisor for specific information.

CONTINUING YOUR COVERAGE AFTER THE LEVEL TERM ENDS

At the end of your level term period, coverage will be continued under the group annual term plan, with premiums adjusted based on 5-year age bands, and you may keep the coverage through age 75. Your coverage amount will not reduce during your level term period. If you are under age 65 at the end of a level term period, coverage will not reduce until age 65. Coverage will reduce to 50% at age 65, to the lesser of 25% of the original face amount or 25,000 at age 70, and terminate at age 75.

If you are age 65 to 70 at the end of a level term period, coverage will reduce to 50%, and thereafter to the lesser of 25% of the original face amount or 25,000 at age 70. If you are age 70 to 75 at the end of a level term period, coverage will reduce to the lesser of 25% or 25,000 and terminate at age 75.



OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AVAILABLE

This plan offers up to \$500,000 of optional AD&D coverage to help with the added expenses that often occur with a sudden, unexpected accident. The AD&D benefit pays your beneficiary an additional amount if you die in a covered accident. In addition, if you are dismembered or lose your sight in a covered accident, you will receive a portion of your coverage, depending on the accident's severity.

SAVE MORE IF YOU QUALIFY AS "SUPER PREFERRED NON-TOBACCO"

Non-tobacco users applying for \$200,000 of coverage or higher and meeting the highest underwriting standards may qualify as "Super Preferred Non-Tobacco," the plan's best rates. Other non-tobacco users that are approved for coverage will qualify for "Preferred Non-Tobacco" rates.



Group Term Life Application for 10-Year or 20-Year Level Term Rate

Please complete the entire application. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to Member Benefits, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256. Phone 800-282-8626; Fax 904-396-2091*

Florida Institute of Certified Public Accountants

Policy No. 31619-9

1. TELL US ABOUT YOURSELF

Member/Employee's Information (complete this section only if applying for Member/Employee coverage on this application):

Name (Last, First, M.I.)		<input type="checkbox"/> Association Member	<input type="checkbox"/> Employee of Member	Name of Member		Member #	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (DD/MM/YYYY)		Place of Birth		Social Security Number	
Address				City		State	Zip
Home/Cell Phone #		Work Phone #		E-mail Address			

Spouse of Member's Information (complete this section only if applying for Spouse of Member coverage on this application):

Name (Last, First, M.I.)		Name of Member		Member #			
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (DD/MM/YYYY)		Social Security Number			
Address				City		State	Zip
Home/Cell Phone #		Work Phone #		E-mail Address			

Dependent Child(ren)'s Information (complete this section only if applying for Dependent Child(ren) on this application):

Number of eligible children: _____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below					
Name _____	DOB _____	SSN _____			
Name _____	DOB _____	SSN _____			
Name _____	DOB _____	SSN _____			
Name _____	DOB _____	SSN _____			
Address		City		State	Zip

	<u>Member/Employee</u>	<u>Spouse</u>
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years? Date of last use (month/year): _____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Are you currently working less than 30 hours per week at your regular occupation and place of business?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. SELECT YOUR COVERAGE

<input type="checkbox"/> 10-Year Level Term	<input type="checkbox"/> 10-Year Level Term	<input type="checkbox"/> 10-Year Level Term
<input type="checkbox"/> 20-Year Level Term	<input type="checkbox"/> 20-Year Level Term	<input type="checkbox"/> 20-Year Level Term
Member Amount	Spouse of Member Amount	Employee of Member Amount
<input type="checkbox"/> Other: \$ _____ in \$5,000 increments (Minimum: \$200,000 Maximum: \$1,000,000)	<input type="checkbox"/> Other: \$ _____ in \$5,000 increments (Minimum: \$200,000 Maximum: \$500,000)	<input type="checkbox"/> Other: \$ _____ in \$5,000 increments (Minimum: \$200,000 Maximum: \$500,000)

Please select if you wish to include additional options with your coverage (If AD&D is elected, benefit will match life amount to a maximum of \$600,000 for member, \$500,000 for spouse and \$250,000 for employee):

- \$10,000 Dependent Child(ren) Coverage*
- Member/Employee Accidental Death & Dismemberment
- Spouse of Member Accidental Death & Dismemberment

* If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

3. PROVIDE YOUR HEALTH INFORMATION

Member/Employee: Height _____ ft. _____ in. Weight _____ lbs. Spouse of Member: Height _____ ft. _____ in. Weight _____ lbs.

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member/Employee: _____ Spouse of Member: _____

- | | <u>Member/Employee</u> | <u>Spouse</u> |
|---|--|--|
| 1) Have you tested positive for exposure to the HIV infection or been diagnosed by a member of the medical profession as having AIDS or ARC caused by the HIV infection or other sickness or condition derived from such infection? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2) Have you ever been diagnosed or treated by a member of the medical profession for: | | |
| a. stroke/TIA (Transient Ischemic Attack) , sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?.. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?.. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4) To the best of your knowledge, have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5) Have you in the last three years flown, or do you anticipate flying in an aircraft within the next two years, other than as a passenger on a scheduled airline? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a. Member/Employee's driver's license number and state of issue: _____ | | |
| b. Spouse of Member's driver's license number and state of issue: _____ | | |
| 7) Have you ever applied for insurance that was declined, postponed or modified in any way?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8) Do you currently have any disorder, condition or disease diagnosed or treated by a member of the medical profession, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For every "Yes" answer to questions in the previous section, give details below. Exclude any additional information regarding treatment for HIV/AIDS/ARC. Please attach a separate sheet if additional space is needed.

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse of Member				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse of Member				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse of Member				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse of Member				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse of Member				



4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Member/Employee Coverage (complete this section only if applying for Member/Employee coverage on this application)

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Beneficiary for Spouse of Member Coverage (complete this section only if applying for Spouse of Member coverage on this application)

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

5. SELECT PAYMENT METHOD

(Choose only one. Option selected is applicable to all coverages approved through this application):

Monthly Auto-Pay. I have included a VOID check and completed the Authorization below.

Upon approval of my application by ReliaStar Life, I hereby authorize Member Benefits to initiate debit and credit entries to my Checking account and the Financial Institution named below to debit and/or credit the same account. Member Benefits will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid within the payment Grace Period. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. Service fees, when applicable by law, may apply for ACH debit returns, Member Benefits and my Bank may discontinue this service. This authority is to remain in full force and effective until Member Benefits has received written notice from me of its termination in such time and manner as to afford Member Benefits and the Financial Institution a reasonable opportunity to act on it.

X _____ / / _____
 Accountholder's Signature Date Name of Financial Institution

Annual Direct Bill. Send No Money Now!

If you select this method, and are approved for coverage, you will receive an initial invoice along with your certificate of insurance, for the required premium to pay your coverage through the end of the group plan year (Dec. 31st). After you pay your initial invoice, you will be invoiced for your full annual premium due January 1st each group plan year.



6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the “effective date” assigned by ReliaStar Life Insurance Company.

Authorization and Acknowledgment – Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, pharmacy prescriptions or prescription records or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life’s Consumer Privacy Notice.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Member/Employee’s Signature	Date	Spouse of Member’s Signature (if applying)	Date
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Privacy Notice



FACTS WHAT DOES VOYA FINANCIAL DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: <ul style="list-style-type: none"> • Social Security number and account balance • Assets and transaction or loss history • Investment experience and employment information
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Voya chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Voya share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	No	We don't share

To limit our sharing	<ul style="list-style-type: none"> • Call our toll-free number (855) 685-9519 – our menu will prompt you through your choice(s) <p>Please note:</p> <p>If you are a <i>new</i> customer, we can begin sharing your information 30 days from the date we sent this notice. When you are <i>no longer</i> our customer, we continue to share your information as described in this notice.</p> <p>However, you can contact us at any time to limit our sharing.</p>
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Questions?	Call the telephone number listed on your statements and other correspondence or go to http://voya.com/contact-us
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Privacy Notice



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Who we are	
Who is providing this notice?	This notice is provided by certain companies owned by Voya Financial, Inc. A list of these companies is provided at the end of this notice.
What do we do	
How does Voya protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Voya collect my personal information?	We collect your personal information, for example, when you <ul style="list-style-type: none"> • open an account or give us your contact information • apply for insurance or seek advice about your investments • tell us about your investment or retirement portfolio We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only <ul style="list-style-type: none"> • sharing for affiliates' everyday business purposes – information about your creditworthiness • affiliates from using your information to market to you • sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your account.

Definitions

Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. <ul style="list-style-type: none"> • Our affiliates include companies with the Voya name; financial companies such as Voya Retirement Insurance and Annuity Company; and nonfinancial companies such as Voya Services Company.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. <ul style="list-style-type: none"> • Voya does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. <ul style="list-style-type: none"> • Voya does not jointly market.

Other important information

We will comply with more restrictive state laws to the extent that they apply. If you live in an "opt-in" state such as California or Vermont, we will obtain your affirmative consent to share your personal information with nonaffiliates who do not currently assist us in servicing your account or conducting our business. If you are a participant in a retirement plan sponsored by your current or former employer, we will not share your personal information to the extent prohibited by your plan sponsor.

Voya affiliates

This notice is provided by: Directed Services LLC; Midwestern United Life Insurance Company; ReliaStar Life Insurance Company; ReliaStar Life Insurance Company of New York; Security Life Assignment Corp.; Security Life of Denver Insurance Company; Voya America Equities, Inc.; Voya Capital Corporation, LLC; Voya Financial, Inc.; Voya Financial Partners, LLC; Voya funds; Voya Funds Services, LLC; Voya Institutional Plan Services, LLC; Voya Institutional Trust Company; Voya Insurance and Annuity Company; Voya Investments, LLC; Voya Investments Distributor, LLC; Voya Retirement Advisors, LLC; Voya Retirement Insurance and Annuity Company