

Application for Individual Term Life Insurance

How to Apply

- Complete the application below for staff member and/or spouse coverage.
 Your spouse must also complete and sign the reverse side if applying for spouse coverage.
- Staff member must complete and sign the Medical Data on the reverse side *ONLY* if:
 - you are applying for more than the Guaranteed Acceptance coverage, or
 - you are applying outside of an authorized Open Enrollment period, or
 - you are applying for an increase to existing coverage.

Consult your benefits office and/or plan brochure for information on the guaranteed coverage amounts.

1. Amount of Coverage

Initial coverage for staff members <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$_____ (other)	Additional coverage for staff member (<i>Staff member must also complete reverse side.</i>) Policy number: _____ <input type="checkbox"/> \$ _____ <input type="checkbox"/> \$ _____ is the total amount of coverage desired under this policy number.
Spouse (<i>Spouse coverage cannot exceed staff member's coverage.</i>) <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$_____ (other)	Children <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000

2. Staff Member's Life Insurance

Name (<i>last, first, middle</i>)		
Residence Address (<i>street, city, state, zip code</i>)		
Birthdate (<i>month, day, year</i>)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Employer		Employment Date
Primary Beneficiary (<i>last, first, middle</i>)		Relationship
Address (<i>street, city, state, zip code</i>)		
Contingent Beneficiary (<i>last, first, middle</i>)		Relationship
Address (<i>street, city, state, zip code</i>)		
a. Are you actively at work on a full-time or part-time basis for your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If "no," give details at right.</i>)		
b. Is this insurance intended to replace or change any life insurance or annuities you now have in force? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>If "yes," give details at right.</i>)		

3. Spouse Life Insurance

Spouse's Name (<i>last, first, middle</i>)	Birthdate (<i>month, day, year</i>)	Social Security Number
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Payroll Deduction Authorization and Agreement

To the best of my knowledge and belief, my statements on this application are complete and true, and I agree that they shall be the basis for any insurance issued.

This insurance will take effect on the later of its approval by ReliaStar Life Insurance Company (ReliaStar Life) or the payday on which my employer, as a service performed for me, begins regular payroll deduction for the premium.

Subject to revocation by me in writing, I hereby authorize _____ (*name of employer*) to deduct from my wages the premium for the above coverage, and to remit such premiums to ReliaStar Life.

Signature of Staff Member	Signature of Spouse (<i>If applying for spouse coverage</i>)	Date Signed (<i>month, day, year</i>)
Signed at (<i>city, state</i>)		
Is this a replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature of Licensed Agent	Premium Payment Mode

For Office Use Only

Group/Account number	GA Amount	GA Effective Date	UW Amount	UW Effective Date
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Complete this side if:

- You are applying for more than the Guaranteed Acceptance amount of coverage during an authorized Open Enrollment period, or
- You are applying for coverage outside of an Open Enrollment period, or
- You are applying for an increase to existing coverage, or
- Your spouse is applying for coverage.

Medical Data – Applicant and Spouse

Staff member's height (<i>feet, inches</i>)	Weight (<i>pounds</i>)
Spouse's height (<i>feet, inches</i>)	Weight (<i>pounds</i>)

Check the appropriate box.

	STAFF MEMBER YES NO	SPOUSE YES NO
1. Have you ever had or been told by a physician that you had any of the following? (<u>Underline each specific condition.</u>) Lung disorders, high blood pressure, heart trouble, nervous disorder, ulcer, liver or stomach disorder, kidney or urinary disorder, diabetes, arthritis, back trouble, cancer, eye or ear impairment, any reproductive organ disorder, or any physical defect or deformity?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2. Have you had medical attention, consulted a physician or been hospitalized in the last 5 years?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
3. At the present time are you under a doctor's care or taking medication for any condition?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
4. Have you ever had life or health insurance declined, postponed, rated, cancelled or renewal refused?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

If you answered "yes" to any of the above questions, please give details below. If the space below is not adequate, please attach an additional sheet.

Staff Member

Question #	Reason for Consultation	Date	Name and Address of Physician

Spouse

Question #	Reason for Consultation	Date	Name and Address of Physician

Home phone number of Staff Member/Spouse ()
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Authorization and Acknowledgement

For underwriting purposes, I give my permission to:

Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar Life) ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, or surgery as they apply to me.

Limitation, if any:

I understand all or part of this information may be sent to MIB, Inc. It may also be made available to any ReliaStar Life reinsurer, employee, or contractor who processes transactions that concern any insurance I may have applied for or have with ReliaStar Life. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulation – 42CFR Part 2. I give my permission to ReliaStar Life to give any and all such information for the purposes described in this form. I specifically consent to the re-disclosure of such information as set forth in this form. I may revoke this authorization as it applies to any information protected by the Federal Regulation at any time, but not to the extent action has been taken in reliance on it.

I understand that my additional written consent will be required before any information 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 a 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 30 months from the date shown below or for 2 years from the date the policy is issued, whichever is earlier. I acknowledge that I have been given ReliaStar Life's INFORMATION PRACTICES NOTICE AND NOTICE REGARDING MIB, INC.

Date of Signature (<i>month, day, year</i>)	Signature of Staff Member
Signed at (<i>city, state</i>)	Signature of Staff Member's Spouse (<i>if applying for spouse coverage</i>)