Life Insurance Application

☐ *ReliaStar Life Insurance Company*
Home Office: Minneapolis, Minnesota 55440
☐ *ReliaStar Life Insurance Company of New York*
Home Office: Woodbury, NY 11797

Administrative Office:
P.O. Box 122, Minneapolis, Minnesota 55440-0122

Product Name _____

Type of Enrollment / Change: *(check all that apply)*

☐ New Application ☐ Increase ☐ Reinstatement ☐ Other _____

Home Office Use Only - Policy Number(s) and Activation Date(s):

Employee	Spouse	Dependent #1	Dependent #2	Dependent #3

Section A. Employer and Billing Information

1. Employer: _____

2. Group Benefit Plan # _____ **3.** Pay Mode: _____

4. Employee ID #: _____ **5.** Dept. #: _____ **6.** Loc. #: _____

Section B. Employee/Owner Information

1. Employee Name: _____

2. Address: _____

City, State, ZIP: _____

3. Phone #: (_____) _____ **4.** Date of Hire: _____ /_____ /_____ **5.** Annual Salary: $ _____

6. Are you actively at work? ☐ Yes ☐ No **7.** Social Security #: _____ – _____ – _____

Section C. Proposed Insured Information

	Employee	**Spouse**	**Dependent Child #1**	**Dependent Child #2**	**Dependent Child #3**
			(Complete only if applying for an individual dependent policy.)		
Name					
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Birthdate	/ /	/ /	/ /	/ /	/ /
Age as of Proposed Effective Date					

	Employee	**Spouse**	**Dependent Child #1**	**Dependent Child #2**	**Dependent Child #3**
Has the proposed insured used tobacco in any form in the last 24 months? *(Respond if 18 years of age or older.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section D. Proposed Insured Questions

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
1. Has the proposed Insured ever been diagnosed and/or treated by a member of the medical profession for positive HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome)?	*Do not answer for Guaranteed Issue coverage.* ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. In the last 90 days, has proposed insured sought or received care or treatment *(including taking any daily or ongoing prescribed medication)*, on an inpatient or outpatient basis, in any hospital, doctor's office or medical care facility for any condition *(excluding pregnancy, birth control, colds/flu, allergies, high blood pressure, elevated cholesterol, heartburn/reflux, back trouble, chiropractic care, wellness exams, or diagnostic testing with normal results)*? **If YES, complete Section F.**	*Do not answer for Guaranteed Issue coverage.* ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section E. Coverage Information

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Death Benefit Option *(Check one only if Universal Life)*	☐ Option A ☐ Option B	☐ Option A ☐ Option B	☐ Option A ☐ Option B	☐ Option A ☐ Option B	☐ Option A ☐ Option B
Face Amount	$	$	$	$	$
Base Weekly Premium	$	$	$	$	$
Excess Weekly Premium *(Applies to Universal Life only)*	$	$	$	$	$

Riders*/Options

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Waiver	☐ Yes				
CTR Number of Units *(Complete Section H)*					
ADB Face Amount	$	$			
FAIR $ per Week	☐ $1.00 ☐ $2.00	☐ $1.00			
ABR **or** LTC **or** ADBR *(Choose Only One)*	☐ ABR ☐ LTC ☐ ADBR	☐ ABR ☐ LTC ☐ ADBR	☐ ABR	☐ ABR	☐ ABR
Level Term to Age 65 *(% and Face Amount)*	_____% $	_____% $			
Other:					
Other:					
Total Weekly Premium	**$**	**$**	**$**	**$**	**$**

*Whole Life Riders: Accelerated Benefit Rider (ABR); Accidental Death Benefit Rider (ADB); Accelerated Death Benefit Rider (ADBR); Children's Term Insurance Rider (CTR); Long Term Care Rider (LTC); Level Term to Age 65 Rider (T65); Waiver of Premium Rider (Waiver).

*Universal Life Riders: Accelerated Benefit Rider (ABR); Accidental Death Benefit Rider (ADB); Children's Term Insurance Rider (CTR); Face Amount Increase Rider (FAIR); Waiver of Monthly Deduction Rider (Waiver).

Section F. Supplemental Questions *(Do not complete this Section if applying for Guaranteed Issue coverage.)*

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
1. Height Weight **Producer:** Does the height and weight exceed the maximum shown on the chart provided?	_____ ft. _____ in. _____ lbs. ☐ Yes ☐ No	_____ ft. _____ in. _____ lbs. ☐ Yes ☐ No	_____ ft. _____ in. _____ lbs. ☐ Yes ☐ No	_____ ft. _____ in. _____ lbs. ☐ Yes ☐ No	_____ ft. _____ in. _____ lbs. ☐ Yes ☐ No
2. Has the proposed Insured been diagnosed with or been treated for: any cardiovascular disease or disorder (excluding high blood pressure and functional/innocent heart murmur), stroke, insulin or non-insulin dependent diabetes (excluding gestational diabetes during pregnancy only), cancer (excluding basal cell carcinoma of the skin and/or squamous cell carcinoma of skin) or benign brain tumors?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has the proposed Insured ever been diagnosed or treated for disorder of the brain (excluding headaches and epilepsy), central nervous system disorder, paralysis, dementia, manic and/or major depression, psychosis or suicide attempt?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Has the proposed Insured ever been diagnosed or treated for chronic lung disease (excluding asthma), sleep apnea, organ transplant, rheumatoid arthritis, chronic blood disorder, or connective tissue disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Has the proposed Insured ever been diagnosed or treated for kidney disease or renal failure, pancreatic disease, liver disease (excluding Hepatitis A), Crohn's disease, or ulcerative colitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Has the proposed Insured sought help or received counseling or treatment for alcohol or drug abuse and not remained substance free for 10 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. In the last 2 years, has the proposed Insured been put on probation or convicted of a felony, Driving Under the Influence (DUI), Driving While Impaired (DWI), or had motor vehicle license revoked or suspended?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. In the last 12 months, has the proposed Insured had a recurrent disability, been disabled, or is disabled now?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "Yes" to any of the above questions, give details below. Attach an additional sheet of paper if necessary.

Question #	Proposed Insured's Name	Name, address and phone number of Physician/Health Practitioner	Condition/Illness/Injury	Date of Treatment	Remaining Effects

Section G. Additional Health Question, Authorization and Acknowledgement for Medical Underwriting

(Complete this Section if applying for an amount requiring Medical Underwriting.)

In the past 5 years, has the proposed Insured consulted a health practitioner or other member of the medical profession, received surgical or medical care or taken prescribed medication for any condition (including current treatment), not already indicated on this application? (If you answer Yes, give details below. Attach an additional sheet of paper if necessary.)	**Employee** ☐ Yes ☐ No	**Spouse** ☐ Yes ☐ No	**Dependent Child #1** ☐ Yes ☐ No	**Dependent Child #2** ☐ Yes ☐ No	**Dependent Child #3** ☐ Yes ☐ No

Proposed Insured's Name	Name, address and phone number of Physician/Health Practitioner	Condition/Illness/Injury	Date of Treatment	Remaining Effects

The responses in this application are complete and true to the best of my knowledge and belief.
I understand that if the policy cannot be issued as applied for, any excess premiums collected will be refunded to the owner. **For underwriting and claim purposes, I give my permission** to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, Medical Information Bureau, Inc (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me, my spouse, or any of my children who are to be insured: and (b) any non-medical information as it applies to me, my spouse, or any of my children who are to be insured. **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 and other insurance companies affiliated with ReliaStar Life to get any and all medical record information for the purposes described 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 permission 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 specifically consent to the re-disclosure of medical record information as set forth in this form. **In connection with any application for life insurance,** or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life. **I understand** that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states that 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 two years from the date shown below. **I acknowledge** that I have been given ReliaStar Life's Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.

Signed at *(City & State):*	On *(Month, Day, Year):*
Signature of Proposed Owner *(Employee):*	Signature of Proposed Insured Spouse:
Signature of Parent or Guardian:	Signature(s) of Proposed Insured Children Age 18 and Older:

This signature is for underwriting authorization only. Please continue completing the application and sign on page 6.

Section H. Proposed Children's Term Insurance Rider (CTR) Information *(Complete this Section if CTR is elected.)*

List all unmarried dependent children who have not attained age 25 on whom Children's Term Insurance is desired. The beneficiary of children's coverage is, in all cases, the Proposed Insured who has the CTR on his/her policy.

Child's First, Middle, Last Name	Birth Date	Relationship	Gender M/F	Is the proposed Insured child hospitalized on the date of this application?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Section I. Replacement Information

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
1. Do you have any existing policies or contracts? (If Yes, complete state Notice Regarding Replacement, if required.) Current Carrier:	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____
2. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If Yes, complete state-required replacement form and provide details.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? (If Yes, complete state-required replacement form and provide details.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Producer: To the best of your knowledge, does this insurance replace any existing insurance or annuities?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section J. Beneficiary Information *(If no beneficiary is designated, the proceeds will be paid to the owner, if living, otherwise to the owner's estate.)*

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Beneficiary #1 Name	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent
Percentage	%	%	%	%	%
Relationship					
Beneficiary #2 Name	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent
Percentage	%	%	%	%	%
Relationship					
Additional Beneficiary Information					

SECTION K: Acknowledgement and Certification / Agreement and Signature

PROPOSED OWNER'S STATEMENT: All statements and answers are complete and true to the best of my knowledge and belief. It is agreed that all such statements and answers shall be made a part of any insurance policy/rider(s) issued.

Fraud Warning: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I UNDERSTAND THAT THE INSURANCE WILL BE EFFECTIVE ON THE POLICY/RIDER(S) EFFECTIVE DATE. I, the owner, acknowledge that I saw a Quotation of Potential Policy Values only, when I applied for my new policy. I know that a complete illustration conforming to the policy as issued will be provided no later than the policy delivery if required by law.

Producer's Statement:
I certify that a Quotation of Potential Policy Values only was used in connection with the sale of the policy applied for, and that I have explained to the applicant that a complete illustration conforming to the policy as issued will be produced and delivered with the policy.
I further certify that I have explained that any nonguaranteed elements of the policy are subject to change. I have made no statements that are inconsistent with the illustration, which will be delivered with the policy if required by law.

PAYROLL DEDUCTION AUTHORIZATION: I authorize my Employer to deduct from my paycheck each pay period such sums certified to my Employer by ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York (ReliaStar Life), or it's affiliate, or their Administrator, as necessary to pay the premium due for my insurance policy(ies). I assign these sums to ReliaStar Life or their Administrator. I authorize my Employer to make future changes in payroll deduction resulting from changes in my ReliaStar Life insurance coverage.

<table>
<tr><td>Proposed Effective Date (Month, Day, Year):</td><td colspan="2">Amendments, Corrections and Notations made by Home Office:</td></tr>
<tr><td>Signed at (City & State):</td><td>On (Month, Day, Year):</td><td>Signature of Proposed Owner (Employee):</td></tr>
<tr><td colspan="2">Producer's Name (please print):</td><td>Signature of Proposed Insured Spouse:</td></tr>
<tr><td colspan="2">Producer's License Number:</td><td>Signature of Parent or Guardian:</td></tr>
<tr><td colspan="2">Signature of Producer:</td><td>Signature(s) of Proposed Insured Children age 18 and Older:</td></tr>
<tr><td colspan="3">Remarks or Special Requests:</td></tr>
</table>