Group Term Life Application

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ***Forrest T. Jones, PO Box 418131, Kansas City, MO, 64141 Phone: 800-821-7303, Fax: 816-751-6032***

The District of Columbia Bar — Policy No. 68596-8 -1

1. TELL US ABOUT YOURSELF

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

Name (Last, First, M.I.)			❑ Male ❑ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

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

Name (Last, First, M.I.)	Name of Member		❑ Male ❑ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	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 eligiblechildren:_____ 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	Home/Cell Phone #

	Member	**Dependent Spouse**
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?	❑ Yes ❑ No	❑ Yes ❑ No
Date of last use (month/year):	_____/_____	_____/_____
b) Are you currently working less than 30 hours per week at your regular occupation and place of business?	❑ Yes ❑ No	❑ Yes ❑ No
c) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	❑ Yes ❑ No	❑ Yes ❑ No

If yes, please explain:_____

2. SELECT YOUR COVERAGE

Member Amount

❑ $100,000
❑ $250,000
❑ $500,000
❑ Other: $_____ *in $10,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Dependent Spouse Amount

❑ $100,000
❑ $250,000
❑ $500,000
❑ Other: $_____ *in $10,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Please select if you wish to include additional options with your coverage:

❑ $5,000 Dependent Child(ren) Coverage
❑ $10,000 Dependent Child(ren) Coverage

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION

Member: **Height_____ft. _____in. Weight_____lbs.** Dependent Spouse: **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:_____ Dependent Spouse:_____

_____ _____

	Member	**Dependent Spouse**
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	❑ Yes ❑ No	❑ Yes ❑ 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?……	❑ Yes ❑ No	❑ Yes ❑ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?……	❑ Yes ❑ No	❑ Yes ❑ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?……	❑ Yes ❑ No	❑ Yes ❑ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?...	❑ Yes ❑ No	❑ Yes ❑ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?...	❑ Yes ❑ No	❑ Yes ❑ 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?.....	❑ Yes ❑ No	❑ Yes ❑ No
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?.....	❑ Yes ❑ No	❑ Yes ❑ No
5) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?.....	❑ Yes ❑ No	❑ Yes ❑ 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? …….....	❑ Yes ❑ No	❑ Yes ❑ No
a. Member's driver's license number and state of issue:_____		
b. Spouse'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?.....	❑ Yes ❑ No	❑ Yes ❑ No
8) Do you currently have any disorder, condition or disease, 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? ……	❑ Yes ❑ No	❑ Yes ❑ No

For every "Yes" answer to questions in the previous section, give details below. 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
	❑ Member ❑Dependent Spouse				
	❑ Member ❑Dependent Spouse				
	❑ Member ❑Dependent Spouse				
	❑ Member ❑Dependent Spouse				
	❑ Member ❑Dependent Spouse				
	❑ Member ❑Dependent Spouse				

PLEASE COMPLETE AND SIGN END OF APPLICATION

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. Attach additional sheets if necessary. Beneficiary for dependent spouse and dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent spouse and dependent child(ren) coverage is attached. Attach additional sheets if necessary.

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

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

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

5. COMPLETE THE FOLLOWNG PAYMENT OPTION SECTION

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

□ **Option 1:** **ELECTRONIC FUNDS TRANSFER (EFT):** □ Monthly

I request and authorize Forrest T. Jones to make withdrawals against the account specified on the attached □ voided check □ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X_____ ___/___/_____

Accountholder's Signature Date

□ **Option 2:** **DIRECT BILL:** □ Quarterly □ Semi-Annual □ Annual

Billing dates will begin after coverage is approved and initial premium has been received.

□ **Option 3:** **CREDIT CARD:** □ Monthly

I request and authorize Forrest T. Jones to charge my bill directly to the credit card listed below.

_____ _____ _____/_____

Name on credit card (EXACTLY as printed) Credit card number Expiration Date

_____

Billing address for credit card – Street, City, State, Zip Code

X_____ ___/___/_____

Accountholder's Signature EXACTLY as name appears on Credit Card Date

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.

PLEASE COMPLETE AND SIGN END OF APPLICATION

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.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Member's Signature	Date	Spouse's Signature (if applying)	Date

Owner of Member Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.)			Date of Birth (MM/DD/YYYY)	Social Security Number
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature				Date