

# ING TERM APPLICATION

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## DO

- Do print in dark ink.
- Do obtain all the necessary signatures.
- Do complete Agent's Report.
- Do have applicant initial all changes.
- Do present the Proposed Insured with the following forms:
  - Consumer Privacy Notice (If a copy will not be presented to Owner.)
  - Authorization for Release of Health Information (A completed copy must also be submitted with the application.)
  - Valuable Information About Your Term Life Insurance Purchase (If a copy will not be presented to Owner.)
- Do present the Owner with the following forms:
  - Consumer Privacy Notice (If a copy will not be presented to Proposed Insured.)
  - Conditional Receipt, when premium has been accepted and the form has been completed and signed. (One copy must be completed and submitted. The second copy is for the Owner's records.)
  - Valuable Information About Your Term Life Insurance Purchase (If a copy will not be presented to Proposed Insured.)
- Do have all checks made payable to ReliaStar Life Insurance Company.

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## DO NOT

- Do not use pencil or correction fluid.
- Do not attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- Do not promise or imply that we will provide insurance.
- Do not accept payment in the form of cash/currency or Traveler's checks.
- Do not accept a check or money order made payable to you or with the payee left blank.
- Do not accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.

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## MAILING OR FAXING INSTRUCTIONS

Mail or Fax all completed materials to the Administrative Office.

Mail to:

ING Service Center  
P.O. Box 5052  
Minot, ND 58702-5052

Fax to:

866-308-7743  
Attn: ING Service Center

**TERM APPLICATION**

ReliaStar Life Insurance Company, Minneapolis, MN

**A. PRODUCT INFORMATION**

- 1. Initial Term Period:  10 Year  15 Year  20 Year  30 Year  Other \_\_\_\_\_
- 2. Face Amount \$ \_\_\_\_\_
- 3. Location of Sale (city, state) \_\_\_\_\_ Date \_\_\_\_\_

**B. RIDER INFORMATION** *Select only if available with product. Not all riders are approved in all states.*

- Waiver of Premium Rider
- Children's Insurance Rider (Complete Children's Insurance Rider Application.) \$ \_\_\_\_\_
- Other \_\_\_\_\_ \$ \_\_\_\_\_

**C. PROPOSED INSURED INFORMATION**

- 1. First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_
- 2. Date of Birth \_\_\_\_\_ Birth State and Country \_\_\_\_\_
- 3. Sex:  M  F Marital Status:  Married  Separated  Divorced  Single  Widowed
- 4. SSN/Government Issued ID# \_\_\_\_\_ Phone \_\_\_\_\_
- 5. Driver's License Number and State \_\_\_\_\_
- 6. Residence Address \_\_\_\_\_  
*(P.O. Boxes are not permitted, other than APO/FPO)* City State ZIP
- 7. Is the Proposed Insured a U.S. Citizen? (If "No", complete the Foreign Travel and Residence Questionnaire.)..... Yes  No
- 8. Occupation (include duties) \_\_\_\_\_
- 9. Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_
- 10. Employer Address \_\_\_\_\_  
City State ZIP
- 11. Proposed Insured Annual Earned Income \_\_\_\_\_ Annual Interest & Other Income \_\_\_\_\_
- 12. Total Net Worth \_\_\_\_\_
- 13. Has the Proposed Insured ever used tobacco or nicotine products of any type? ..... Yes  No  
If "Yes", indicate Type \_\_\_\_\_ Amount & Frequency \_\_\_\_\_ Month/Year Last Used \_\_\_\_\_

**D. PROPOSED INSURED PERSONAL HISTORY**

- 1. Has the Proposed Insured ever declared bankruptcy? (If "Yes", provide details in chart below, including date discharged.)..... Yes  No
- 2. Is the Proposed Insured, or do they intend to become a member of the armed forces, including the Reserves or National Guard? (If "Yes", complete Military Questionnaire.)..... Yes  No
- 3. In the next 5 years, does the Proposed Insured intend to travel or reside outside the United States or Canada (other than a two week or less vacation to Western Europe or the Caribbean)? (If "Yes", complete the Foreign Travel and Residence Questionnaire.)..... Yes  No
- 4. Does the Proposed Insured anticipate flying a plane (other than as a commercial pilot), racing motor boats, automobiles or motorcycles, or participating in sky-diving, hang-gliding or other hazardous activities? (If "Yes", complete the appropriate hazardous activities questionnaire.)..... Yes  No

5. Except for traffic violations, has the Proposed Insured been the subject of or convicted in a criminal proceeding?  
 (If "Yes", provide details in chart below.).....  Yes  No
6. Has the Proposed Insured in the last five years had any motor vehicle accidents, alcohol or drug related convictions,  
 or other moving violations while operating a motor vehicle? (If "Yes", provide details in chart below.).....  Yes  No

For any "Yes" answer to questions 1, 5 or 6, please record information in the chart below.

Ques. #	Explanation

**E. BENEFICIARY INFORMATION**

Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.

Name (First, MI, Last)	DOB	Relationship	%	Beneficiary Type
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

If beneficiary is a Trust or Corporation, provide name and date of trust agreement and state of incorporation.

Name of Trust/Corporation \_\_\_\_\_ Date of Trust \_\_\_\_\_ State of Incorporation \_\_\_\_\_

**F. OWNER (PAYOR) Complete only if owner is to be other than Proposed Insured.**

1. Owner is:  Individual  Corporation  Trust  Sole Proprietorship  Partnership  Other \_\_\_\_\_

2. Full Name \_\_\_\_\_

3. Relation to Proposed Insured \_\_\_\_\_

4. Residence Address \_\_\_\_\_  
 (P.O. Boxes are not permitted other than APO/FPO) City State ZIP

5. Billing Address \_\_\_\_\_  
 City State ZIP

6. Phone \_\_\_\_\_ SSN/TIN or Government Issued ID# \_\_\_\_\_

7. Driver's License Number/State (individual only) \_\_\_\_\_ Date of Birth \_\_\_\_\_

8. Trust Contact Name \_\_\_\_\_ Date of Trust \_\_\_\_\_

9. Type of Trust:  Revocable  Irrevocable Purpose of the Trust \_\_\_\_\_

10. State of Incorporation \_\_\_\_\_ Name of Trustee/Corporate Officer \_\_\_\_\_

11. Does the above trustee have sole authority to act on behalf of the Trust? .....  Yes  No  
 (If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees.)

**G. REPLACEMENT INFORMATION (Applies to both Owner and Proposed Insured.)**

If you intend to replace existing coverage, tell the Agent of your intention and answer "Yes" to the replacement questions (#2 and #3 below). State law may require the Agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Agent if you are unsure.

- |  | Proposed Insured         |                          | Proposed Owner           |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
|  | Yes                      | No                       | Yes                      | No                       |
| 1. Do you have an existing or pending life insurance policy or annuity contract? (If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.) .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you considering using funds from an existing policy or contract to pay premiums on the policy you are applying for? (If "Yes", complete state required replacement form and provide details below.) .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you discontinued making premium payments, surrendered, forfeited, assigned to the insurer, or otherwise terminated an existing policy or contract or are you considering doing so? (If "Yes", complete state required replacement form and provide details below.) ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name	Insurance Company (Do not include group policies.)	Contract / Policy #	Account Value / Amount of Coverage	Date Issued

**H. PAYMENT INFORMATION**

1. Initial Payment:  Check  COD  ~~Credit Card~~ (When available and selected, see #4 Credit Card Information.)  
 Military Allotment (Active or retired military members must complete Military Allotment form and return to the Military finance department.)  
 Civil Service Allotment (Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit must be completed.)
2. Initial Payment Amount \$ \_\_\_\_\_ Subsequent Payment Amount \$ \_\_\_\_\_
3. Frequency of Subsequent Payments:  
 Annual  Semi-Annual  Quarterly  Monthly (Complete EFT form-Appendix E)
4. Credit Card Payment (When available):  Visa  MasterCard  Discover  American Express  
 Full Name (Print as it appears on card) \_\_\_\_\_  
 Card Number \_\_\_\_\_ N/A \_\_\_\_\_ N/A \_\_\_\_\_ Expiration Date \_\_\_\_\_ N/A \_\_\_\_\_
5. Would you like to backdate your policy to save age? (If "Yes", see backdating disclosure, section M.).....  Yes  No

**I. MEDICAL TRANSFER STATEMENT (Complete when submitting medical examinations from another insurance company.)**

1. Name of Insurance Company \_\_\_\_\_ 2. Date of Examination \_\_\_\_\_
3. To the best of your knowledge and belief, are the statements in the examination true and complete today?.....  Yes  No
4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 2 above? (If "Yes", please provide details below.).....  Yes  No

**J. REPLACEMENT VERIFICATION (For Agent use ONLY)**

1. To the best of your knowledge and belief, will coverage under an existing life insurance policy or annuity contract be replaced, lapsed, surrendered, or borrowed against in relation to this application for insurance? (If "Yes", submit state required replacement forms.).....  Yes  No
2. Is the Owner or the Proposed Insured considering using funds from an existing policy or contract to pay premiums on the policy being applied for? (If "Yes", complete state required replacement forms and provide details below.) .....  Yes  No
3. Has the Owner or the Proposed Insured discontinued making premium payments, surrendered, forfeited, assigned to the insurer, or otherwise terminated an existing policy or contract or are they considering doing so? (If "Yes", complete state required replacement form and provide details below.) .....  Yes  No
- Company \_\_\_\_\_ Policy # \_\_\_\_\_ Amount \_\_\_\_\_

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## K. IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to:

ING Service Center  
Life New Business  
P.O. Box 5052  
Minot, ND, 58702-5052.

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## L. STATE REQUIRED NOTICES

**For Applicants in Arkansas, District of Columbia, Hawaii, Louisiana, Oklahoma and Tennessee:**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime and in certain states, a felony. Penalties may include imprisonment, fine, denial of benefits, or civil damages.

**The laws of the following states require that we provide these notices:**

### **COLORADO:**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

### **KENTUCKY:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

### **NEW JERSEY:**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### **OHIO:**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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## M. BACKDATING DISCLOSURE

As a policyholder, you may elect to backdate your policy, which enables you to gain benefits of a lower age for the purposes of calculating costs of insurance charges on your policy.

There are some inherent costs associated with your decision to backdate your policy. For each month that your policy is backdated the applicable costs of insurance charges are accumulated and deducted from your initial premium payment. If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

**This page must be given to the Proposed Insured.**

**N. AUTHORIZATION AND ACKNOWLEDGEMENT**

The undersigned Owner and Proposed Insured declare: By completing this life insurance application, I understand that I am applying for life insurance coverage issued by ReliaStar Life Insurance Company, referred to as the "Company." I understand and consent that this application and information obtained pursuant to this authorization may be used by the Company to evaluate my eligibility for life insurance. For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, clinic or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), any consumer reporting agency, or any other organization to release to the Company or their authorized representatives (including any consumer reporting agency) acting on their behalf, ALL INFORMATION requested by the Company about me and any minor children who are to be insured. This includes but is not limited to: Any medical information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and treatment of me or my minor children who are to be insured; Prescription drug records and related information maintained by physicians, pharmacy benefit managers and other sources; Any non-medical information about me or my minor children who are to be insured. By this authorization, each physician, medical practitioner, hospital, clinic or medically related facility contacted by the Company is instructed to provide the entire medical record in its possession concerning me or any minor children who are to be insured.

- I give my permission to the Company to collect consumer or investigative consumer reports about these same persons.
- I give my permission to the Company and other insurance companies affiliated with the Company to collect 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 - 42CFR Part 2. I may revoke this permission and authorization as it applies to any information protected by 42CFR Part 2 or by applicable state law at any time by mailing the written revocation to the Company at the address on the Consumer Privacy Notice, but not to the extent action has been taken. I understand that the release of medical records will not be requested with respect to tests performed to determine the presence of the Human Immunodeficiency Virus (HIV) antibody.

For any life insurance application or other insurance transaction that I may have with the Company, I specifically consent that some or all of the information obtained by this authorization may be sent to MIB, reinsurers, the agent who solicited my application and his or her principals, employees

or contractors who process transactions regarding any insurance coverage I may have applied for or have with the Company or affiliated companies. I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy.

- **I understand that I may request to be interviewed if an investigative consumer report is prepared. You may contact me between the hours of \_\_\_\_\_ am/pm and \_\_\_\_\_ am/pm. My daytime phone number is ( \_\_\_\_\_ ) \_\_\_\_\_.**
- **I know that I have a right to receive a copy of this form and a photocopy will be as valid as the original.**
- **This form will be valid for 24 months from the date shown below.**
- **I acknowledge receipt of the following notices: Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.**

**VERIFICATION:**

Each of the undersigned also declares that:

- I have read the statements and answers given in this application and affirm that they are true and complete to the best of my knowledge and belief. I understand that the Company may seek to rescind or cancel the insurance coverage if there is any material misrepresentation.
- This application consists of Part I, appendices and supplemental questionnaires, and will be the basis for any coverage issued on this application. Any coverage issued on this application will take effect only upon satisfaction of all of the Company's requirements, except as otherwise provided in the Conditional Receipt, if issued, with the same date as this application. Except where permitted expressly by statute or regulation, no agent or medical examiner has the authority to waive the answer to any question in the application, to pass on insurability, to make or alter any contract or waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, plan of insurance or benefits on this application shall be effective unless agreed to in writing by the Proposed Insured and Owner.
- I certify, under penalty of perjury, that my Social Security/tax identification number(s) is(are) shown and is(are) correct and that I am not subject to back-up withholding.

**All completed materials must be sent to the Administrative Office at: ING Service Center, P.O. Box 5052, Minot, ND 58702-5052 or faxed to 866-308-7743.**

Signature of Proposed Insured (if age 15 or older) \_\_\_\_\_

Signed at: (city/state) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Owner (if other than the Proposed Insured) \_\_\_\_\_ Date \_\_\_\_\_

Print Owner/Trustee Name \_\_\_\_\_

Signature of Parent or Guardian (if the Proposed Insured is a minor) \_\_\_\_\_

Signature of Writing Agent \_\_\_\_\_

Print Writing Agent Name \_\_\_\_\_

Writing Agent State Lic. # \_\_\_\_\_ Writing Agent # \_\_\_\_\_

Name of Agent \_\_\_\_\_

Agent State Lic. # \_\_\_\_\_ Agent # \_\_\_\_\_

# AGENT'S REPORT

To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.

Agent Name (Please Print.)	Agent ID #	% Split	General Agent #	General Agent Name

Each licensed agent will share equally unless otherwise indicated.

## A. COMPLIANCE INFORMATION

1. Have you delivered the Consumer Privacy Notice to the Proposed Insured(s) or Proposed Owner? .....  Yes  No
2. Did you meet personally with the applicant/owner and review their SSN/Government issued ID? (If "No", explain below.) .....  Yes  No
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Owner?.....  Yes  No
4. Will there be a rebate of any kind, such as a rebate of premium, to the Owner? .....  Yes  No
5. To your knowledge, does the Owner intend to change ownership of the policy after its issuance (i.e. to a trust, viatical or life settlement company or other person)? .....  Yes  No
6. Will any portion of the premiums for this policy be financed? .....  Yes  No
7. All sales materials have been approved by the Insurer, and the following were used in my sales presentation: \_\_\_\_\_
8. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policyowner no later than at the time of the policy delivery.) Our Company requires that all replacement sales are made in accordance with the Company's corporate policy. If this particular sale is NOT in accordance with the Company's corporate replacement policy, please check here  and attach an explanation.

## B. PROPOSED INSURED/OWNER INFORMATION

1. How long have you known the Proposed Insured? \_\_\_\_\_
2. Are you related?  Yes  No How? \_\_\_\_\_
3. How much insurance does the Proposed Insured's spouse own payable to the Proposed Insured or other dependents? \$ \_\_\_\_\_
4. If this application is for a juvenile, please indicate the amount of life insurance in force on each parent or sibling.  
 Father \$ \_\_\_\_\_ Mother \$ \_\_\_\_\_ Sibling \$ \_\_\_\_\_
5. Please check the Underwriting requirements ordered:  Blood Profile/HOS  Inspection Report  MD Exam  
 Treadmill EKG  EKG  Paramedical Exam Paramed Company \_\_\_\_\_

## C. REMARKS

Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.

## D. ACKNOWLEDGEMENT

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent or Producer Agreement ("Agreement"), whichever is applicable, including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker/Dealer and do not hold an Agreement such that this language is inapplicable.

I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

## E. AGENT SIGNATURE

Agent Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

Contact for Requirements \_\_\_\_\_ Agent SSN \_\_\_\_\_

Agent Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email Address \_\_\_\_\_

# CONDITIONAL RECEIPT

ReliaStar Life Insurance Company, Minneapolis, MN

**IF WITHIN THE LAST YEAR, THE PROPOSED INSURED HAS RECEIVED ANY TREATMENT OR ADVICE FROM A PHYSICIAN FOR TUMOR OR CANCER OR ANY BRAIN, HEART, LUNG OR KIDNEY DISORDER, A CONDITIONAL RECEIPT MAY NOT BE GIVEN AND PREMIUM MAY NOT BE COLLECTED.**

Premium received from \_\_\_\_\_  
in the amount of \$ \_\_\_\_\_ in payment of the first full  
modal premium for an insurance policy applied for on the life  
of \_\_\_\_\_

**This Conditional Receipt does not create temporary or interim insurance and it does not provide any coverage except as provided herein. If any of the below questions are answered YES or LEFT BLANK, the agent is not authorized to accept a premium, and there will be NO COVERAGE. Premium may be paid by check, authorized withdrawal or credit card payment. Make all checks payable to the Company, not the agent.**

*Proposed Insured, for whom this application as dated below has been made to ReliaStar Life Insurance Company.*

### I. REPRESENTATIONS — Applicable to the Proposed Insured named above.

1. Has the Proposed Insured:
  - a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which the Proposed Insured has not consulted a physician? .....  Yes  No
  - b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?.....  Yes  No
  - c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the immune system? .....  Yes  No
  - d. attained age 70?.....  Yes  No
2. For the Proposed Insured, is the initial amount of life insurance applied for on all applications pending with the Company plus the current amount of all existing life insurance with the Company more than \$1,000,000? .....  Yes  No
3. For the Proposed Insured, does existing life insurance with all insurers plus amount applied for in pending application(s) with all insurers exceed \$10,000,000? (For #2 and #3 amount of insurance calculations, include all policies, term riders, and accidental death coverage and second to die coverage for the Proposed Insured.).....  Yes  No

### II. TERMS AND CONDITIONS OF COVERAGE UNDER THIS RECEIPT

**Amount of Coverage:** If the Proposed Insured dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders if issued as applied for under the Application; or (b) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or conditional receipts on the life of Proposed Insured, the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured.

**General:** Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. All the above representations are true and complete to the best of my knowledge and belief. I agree that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

**Coverage begins** when premium has been accepted, and this form has been completed and signed.

- Coverage ends** automatically on the earliest of the following dates:
- Five days after a refund of premium is mailed to the Owner's address shown on the application; or
  - Five days after a notice of termination is mailed to the Owner's address shown on the application; or
  - Coverage starts under any policy resulting from the Application; or
  - A policy resulting from the Application is refused; or
  - 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

- There is no insurance coverage if:**
- There is material misrepresentation in the answers to the questions above or to any question or statement in the Application.
  - The Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
  - The premium check, authorized withdrawal or credit card payment is not honored.

Owner Signature \_\_\_\_\_ Date \_\_\_\_\_ Signed at (city/state) \_\_\_\_\_

Proposed Insured Signature \_\_\_\_\_ Date \_\_\_\_\_ Signed at (city/state) \_\_\_\_\_

Licensed Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent Name (please print) \_\_\_\_\_ Agent Phone \_\_\_\_\_

# CONDITIONAL RECEIPT

ReliaStar Life Insurance Company, Minneapolis, MN

**IF WITHIN THE LAST YEAR, THE PROPOSED INSURED HAS RECEIVED ANY TREATMENT OR ADVICE FROM A PHYSICIAN FOR TUMOR OR CANCER OR ANY BRAIN, HEART, LUNG OR KIDNEY DISORDER, A CONDITIONAL RECEIPT MAY NOT BE GIVEN AND PREMIUM MAY NOT BE COLLECTED.**

Premium received from \_\_\_\_\_  
in the amount of \$ \_\_\_\_\_ in payment of the first full  
modal premium for an insurance policy applied for on the life  
of \_\_\_\_\_

**This Conditional Receipt does not create temporary or interim insurance and it does not provide any coverage except as provided herein. If any of the below questions are answered YES or LEFT BLANK, the agent is not authorized to accept a premium, and there will be NO COVERAGE. Premium may be paid by check, authorized withdrawal or credit card payment. Make all checks payable to the Company, not the agent.**

*Proposed Insured, for whom this application as dated below has been made to ReliaStar Life Insurance Company.*

### I. REPRESENTATIONS — Applicable to the Proposed Insured named above.

1. Has the Proposed Insured:
  - a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which the Proposed Insured has not consulted a physician? .....  Yes  No
  - b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?.....  Yes  No
  - c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the immune system? .....  Yes  No
  - d. attained age 70?.....  Yes  No
2. For the Proposed Insured, is the initial amount of life insurance applied for on all applications pending with the Company plus the current amount of all existing life insurance with the Company more than \$1,000,000? .....  Yes  No
3. For the Proposed Insured, does existing life insurance with all insurers plus amount applied for in pending application(s) with all insurers exceed \$10,000,000? (For #2 and #3 amount of insurance calculations, include all policies, term riders, and accidental death coverage and second to die coverage for the Proposed Insured.).....  Yes  No

### II. TERMS AND CONDITIONS OF COVERAGE UNDER THIS RECEIPT

**Amount of Coverage:** If the Proposed Insured dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders if issued as applied for under the Application; or (b) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or conditional receipts on the life of Proposed Insured, the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured.

**General:** Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. All the above representations are true and complete to the best of my knowledge and belief. I agree that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

**Coverage begins** when premium has been accepted, and this form has been completed and signed.

- Coverage ends** automatically on the earliest of the following dates:
- Five days after a refund of premium is mailed to the Owner's address shown on the application; or
  - Five days after a notice of termination is mailed to the Owner's address shown on the application; or
  - Coverage starts under any policy resulting from the Application; or
  - A policy resulting from the Application is refused; or
  - 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

- There is no insurance coverage if:**
- There is material misrepresentation in the answers to the questions above or to any question or statement in the Application.
  - The Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
  - The premium check, authorized withdrawal or credit card payment is not honored.

Owner Signature \_\_\_\_\_ Date \_\_\_\_\_ Signed at (city/state) \_\_\_\_\_

Proposed Insured Signature \_\_\_\_\_ Date \_\_\_\_\_ Signed at (city/state) \_\_\_\_\_

Licensed Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent Name (please print) \_\_\_\_\_ Agent Phone \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

ReliaStar Life Insurance Company, Minneapolis, MN

Administrative Office:  
ING Service Center  
P.O. Box 5052  
Minot, ND 58702-5052

**This authorization complies with the HIPAA Privacy Rule.**

Name of Proposed Insured/Patient (please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address of Proposed Insured/Patient \_\_\_\_\_

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to "the Company" and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that "the Company" may: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and

5) conduct other legally permissible activities that relate to any coverage I have or have applied for with "the Company".

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to "the Company", Attention: Privacy Official, ING Service Center, P.O. Box 5052, Minot, ND, 58702-5052. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that "the Company" has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, "the Company" may not be able to process my Application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Description of Personal Representative's Authority or Relationship to Patient (please print) \_\_\_\_\_

**A copy of this Authorization must be given to the Proposed Insured.**

## CONSUMER PRIVACY NOTICE

### Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with ReliaStar Life Insurance Company (the "Company"). You may request that this information not be communicated to other companies affiliated with the Company.

The information may be kept by the consumer reporting agency. It may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

### Notice Regarding MIB (Medical Information Bureau, Inc.)

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is 866-692-6901 and fax is 866-346-3642.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

### Notice Regarding Information Practices

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

**This page must be given to the Proposed Insured and/or Owner.**

## VALUABLE INFORMATION ABOUT YOUR TERM LIFE INSURANCE PURCHASE

ReliaStar Life Insurance Company, Minneapolis, MN  
Security Life of Denver Insurance Company, Denver, CO



Thank you for considering ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company") for your life insurance needs. We offer various life insurance products that have different features, benefits and costs. Your professional insurance agent may work with many life insurance companies, and we are pleased that your agent has presented one of our products to you.

We'd like you to understand how we pay the selling agent. Agents earn a commission for each Company policy sold. The commission is generally a percentage of the policy premiums you pay. The percentage may be higher for agents that sell a larger number of Company policies. Agents may receive additional compensation for each year a policy remains in force or for achieving certain sales volume levels. The actual percentage and amount of compensation paid will vary based on the specific circumstances of your purchase.

Agents may receive additional non-cash compensation from us as a reward for things like achieving sales contest objectives or other measures. We also may pay for agent education, training or attendance at conventions, and may provide financing, or other payments or benefits. In addition, some agents may be associated with independent marketing organizations ("IMOs") that have agreements with us. IMOs provide administrative services to independent agents and marketing support for our policies. The Company may make payments to IMOs that may be based on the amount of premium written with the Company by agents associated with the IMO.

This is a general discussion of the compensation we pay for the sale of our policies. We pay commissions and other sales expenses from our general assets and revenues, including amounts we earn from fees and charges under our policies. The price of an insurance policy is set by the Company and reflects the compensation we pay for the sale of the policies. It also covers costs we incur for the design, manufacture and service of our policies, for policy benefits and features including guarantees, and for the investment management needed to support the policies' values. We are committed to providing top-quality insurance products to our customers and are pleased that your professional insurance agent trusts us to deliver on your long-term insurance needs.

**This notice must be given to the Proposed Insured/Owner.**



**B. ELECTRONIC FUNDS TRANSFER (Continued)**

**Tape voided check here.** Forms submitted without a voided check will not be accepted.  
Deposit slips will only be accepted in lieu of voided checks for Savings Accounts.

**Terms of the EFT Plan** Each debit will be: (1) in an amount sufficient to pay a proper proportion of the annual premium at the Company's EFT premium rate; (2) notice of premium due and no further notice of premium will be given; (3) a receipt for the amount stated thereon if and when the Company receives actual payment. If a debit is not honored by the bank upon presentation for payment by the Company, such action by the bank will be notice of nonpayment of premium. The EFT Plan for premium payment may be terminated by the Policyowner or by the Bank Depositor/premium payor by written notice filed with the Company and may be terminated by the bank in which the Account is maintained. The Company also may terminate without notice if any debit is not honored upon presentation, otherwise upon 30 days written notice to the Policyowner. In the event the Plan is terminated for any cause, any unpaid premiums, and premiums which have due dates that occur on or after the date of termination, will be paid directly to the Company at the premium rate and on the premium due date which would have been applicable to each policy if it had not been placed under the EFT Plan for premium payment. If the Company is not paid within the time required by the policies, the said policies will lapse and have no further value, except as otherwise provided in said policies. The Company may, at its discretion from time to time, effect payments by use of prearranged payments (debit) or an electronic bank debit system. **It is agreed that:** This authorization will apply to any conversion, renewal or change made in said policies; the Company encourages the Policyowner to obtain overdraft protection from its bank to avoid any unhonored withdrawals and associated fees; the Company may increase the premium withdrawal amount sufficient to maintain insurance coverage. Such increase would occur 30 days after providing written notification of the increase. **Authorization Agreement for Prearranged Payments (debits)** I (we) authorize the Company to make variable charges to my (our) checking or savings Account identified above, and authorize the financial institution named above to withdraw funds from (debit) such Account and pay to the Company's order accordingly. This authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me (us) to terminate this agreement. I have read and understand the above statement:

Signature of Account Owner \_\_\_\_\_ Date \_\_\_\_\_

SSN/TIN \_\_\_\_\_ Phone \_\_\_\_\_



Examiner \_\_\_\_\_

Address \_\_\_\_\_

Insurer Name \_\_\_\_\_

Insurer Address \_\_\_\_\_

## NOTICE AND CONSENT FOR BLOOD, URINE AND OR ORAL FLUID TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING - WEST VIRGINIA

To determine your insurability, the insurer named above, (the Insurer) has requested that you provide a sample of your blood, urine and/or oral fluids for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS Virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. This series of tests directly identifies AIDS viral particles. This series of tests is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have applied for with the Insurer, the Insurer may disclose test results to others such as its reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other as may be required or permitted by law or as authorized by you. If you desire, you have the right to request a complete list of the parties to whom the Insurer has released test information.

You should also be aware that the health care professional who performs the blood, urine and/or oral fluid testing is subject to West Virginia Code Sections 16-3C-3 and 16-3C-4 which authorize that they may disclose test results to certain limited individuals under certain limited circumstances [these relate primarily to (1) persons you authorize to see the test results, (2) health care providers who may come into contact with you or specimens obtained from you (3) the United States centers for disease control, (4) a court order to release the results, and (5) identified sex partners and persons sharing needles.] These persons are required by West Virginia Code Section 16-3C-3 and 16-3C-4 to keep test information confidential.

You may direct that test results be disclosed directly to you or if you prefer to your personal physician or other health care professional. It is strongly suggested that you designate a physician or health care professional to receive your test results so that they may properly explain the results to you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which in the Insurer's opinion, are significant. If you have not already indicated one, the Insurer may ask you at that time for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant abnormalities discovered in the body fluid sample tested for the presence of HIV will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I wish my test results to be released to (check one only):

- Me Only
- My physician, health care provider, or other persons indicated below
- Both me and my physician, health care provider or other persons indicated below.

Physician, Health Care Provider, or other Person:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

I have read and I understand this notice and consent for blood, urine and/or oral fluid testing which may include HIV Antibody/Antigen testing. I voluntarily consent to give a urine or oral fluid specimen and/or to the withdrawal of blood from me, the testing of that urine and/or blood or oral fluid, and the disclosure of the test results as described.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Name of Proposed Insured

\_\_\_\_\_  
Proposed Insured's Date of Birth

\_\_\_\_\_  
State of Residence

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

### THIS AUTHORIZATION EXPIRES AFTER 60 DAYS.

**5.10** If an initial ELISA test is negative, or both repeat-duplicate tests are negative, the testing ceases and the proposed insured cannot be denied coverage based on AIDS-related testing. If the initial and at least one of the repeat-duplicate ELISA tests is positive but the Western blot test is negative, for purposes of insurability, the results are negative.



ReliaStar Life Insurance Company  
Home Office: Minneapolis, MN  
Administrative Office:  
P.O. Box 5075  
Minot, ND 58702-5075

## **LIVING BENEFIT RIDER DISCLOSURE STATEMENT**

The accelerated benefit rider, better known as ReliaStar's Living Benefit Rider, allows the owner to access a portion of the life insurance death benefit if the insured becomes terminally ill (life expectancy of 6 months or less as determined by a physician). The benefit is always payable to the owner.

There is no additional premium required to issue this rider. If you request an accelerated benefit, an interest charge and an administrative expense charge will be deducted from the amount you request.

When an accelerated benefit is paid, the death benefit, cash values and loan values of the policy will be reduced proportionally. The amount will be determined at the time you request a Living Benefit payment.

For example, suppose you purchase a policy with a \$100,000 death benefit. Later, you request a Living Benefit payment of \$25,000. Any charges noted above would be deducted from the \$25,000 and the resulting total would be your Living Benefit payment. The death benefit on your policy would then be reduced to \$75,000, and any required premium would be reduced proportionally. If your policy has cash values, those accumulations would also be reduced proportionally.

Limitations of the Accelerated Benefit:

- (a) The rider is not intended to replace health or disability coverage. Rather, it provides an added source of funds to meet critical needs during a difficult time. You choose how the funds will best meet your needs. There are no restrictions on how a Living Benefit payment can be used.
- (b) Accelerated benefits payable under this rider may or may not be taxable. You should consult your personal tax advisor.
- (c) Receipt of accelerated benefits under this product may affect medicaid and supplemental security income ("SSI") eligibility.

If at some future point in time, you decide that you no longer wish to carry the Living Benefit Rider on your coverage, you may request that it be removed. The Living Benefit Rider will automatically terminate when the life insurance policy matures.

The Living Benefit Rider is subject to eligibility requirements.

## ACCELERATED BENEFIT RIDER DISCLOSURE

ReliaStar Life Insurance Company, Minneapolis, MN  
 A member of the ING family of companies  
 ING Customer Service Center: P.O. Box 5075, Minot, ND 58702-5075



## READ YOUR RIDER CAREFULLY

**Receipt of the accelerated benefit could be taxable. You should consult your personal tax advisor to assess the impact of this benefit. Receipt of the accelerated benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. The accelerated benefit is not intended to provide health, nursing home or long-term care insurance. Policy cash values and loan values, if any, will be reduced if you receive an accelerated benefit under the rider.**

- We will pay the accelerated benefit, at your request, if the insured has a terminal illness. A terminal illness is a non-correctable medical or physical condition that with reasonable medical certainty will result in the death of the Insured in 12 months or less from the date of the Physician statement.
- You may request an acceleration of a portion of your Eligible Death Benefit of an amount no less than \$5,000 and not to exceed the lesser of 25% or \$250,000. The benefit ratio is equal to the amount you request divided by the Eligible Death Benefit. We will pay you the amount you requested reduced by:
  - An amount equal to any outstanding Policy loan and accrued interest multiplied by the benefit ratio;
  - An actuarial discount based on the annual rate of interest declared by us; and
  - An administrative charge of \$150.

The remainder will be paid to the policyowner. Limitations, as described in the Accelerated Benefit Rider, may apply.

- The accelerated benefit will be paid in a lump sum unless you request and we agree to payment in some other manner.
- After an accelerated benefit payment is made, the policy's death benefit, its cash value, if any, and its required premium, if any, will be reduced by the benefit ratio. Additionally, any outstanding policy loan will be reduced by the portion of the policy loan and accrued interest which was deducted from your payment.

This summary provides a brief description of the important features of your Accelerated Benefit Rider. An example of the effect of an accelerated benefit request of \$25,000 is shown below.<sup>1</sup>

Before Acceleration		Requested Acceleration = \$25,000		After Acceleration	
Death Benefit	\$100,000.00	Benefit Ratio	25%	Death Benefit	\$75,000.00
Cash Value	\$30,000.00	Benefit Reductions		Cash Value	\$22,500.00
Policy Loan	\$10,000.00	<i>Loan Repayment</i>	\$2,500.00	Policy Loan	\$7,500.00
Required Premium	\$1,000.00	<i>Actuarial Discount<sup>2</sup></i>	\$625.00	Required Premium	\$750.00
Cash Surrender Value	\$20,000.00	<i>Administrative Charge</i>	\$150.00	Cash Surrender Value	\$15,000.00
		Net Payment to Owner	\$21,725.00		

I acknowledge that I have received and read this summary which has been furnished to me on this date.

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_

Signature of Policyowner \_\_\_\_\_ Date \_\_\_\_\_

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>This example is illustrative only and is not intended to show actual values.

<sup>2</sup>Assumes hypothetical interest rate of 5%.

# AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization is HIPAA compliant.

## PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(please print)* \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/ITIN \_\_\_\_\_

Proposed Insured/Patient Address \_\_\_\_\_

## AUTHORIZATION INFORMATION

This will authorize:

\_\_\_\_\_ *(Physician, Clinic or Hospital Name)*

to release medical information to \_\_\_\_\_ *(the Life Insurance Agent/Agency).*

Authorized Life Insurance Carrier(s) \_\_\_\_\_

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, according to the terms of this authorization. This includes any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Insurance Agent/Agency named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Insurance Agent/Agency may provide the information to the listed carrier(s) so that they may: 1) underwrite

my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Insurance Agent/Agency.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Insurance Agent/Agency named above at the following address.

Attention: Privacy Official

Agency Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Proposed Insured/Patient or  
Personal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Description of Personal Representative's  
Authority or Relationship to Patient *(please print)* \_\_\_\_\_

**A copy of this authorization must be given to the Proposed Insured.**

**IMPORTANT NOTICE:  
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**



(Refer to mailing address on application)

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy or an annuity contract involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract or meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? .....  Yes  No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? .....  Yes  No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financing (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Producer's Signature \_\_\_\_\_ Date \_\_\_\_\_

**I do not want this notice read aloud to me. \_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)**

**(1st Copy - Service Office, 2nd Copy - Client, 3rd Copy - Producer)**

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A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement of financing your purchase makes sense:

**PREMIUMS:** Are they affordable?  
Could they change?  
You're older—are premiums higher for the proposed new policy?  
How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:** New policies usually take longer to build cash values and to pay dividends.  
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.  
What surrender charges do the policies have?  
What expense and sales charges will you pay on the new policy?  
Does the new policy provide more insurance coverage?

**INSURABILITY:** If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.  
You may need a medical exam for a new policy.  
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.  
Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected?  
Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

What are the tax consequences of buying the new policy?  
Is this a tax free exchange? (See your tax advisor.)  
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?  
Will the existing insurer be willing to modify the old policy?  
How does the quality and financial stability of the new company compare with your existing company?

**(1st Copy - Service Office, 2nd Copy - Client, 3rd Copy - Producer)**



ReliaStar Life Insurance Company  
 Home Office: Minneapolis, MN  
 Administrative Office:  
 P.O. Box 5075  
 Minot, ND 58702-5075

Security Life of Denver Insurance Company  
 Home Office: Denver, CO  
 Administrative Office:  
 P.O. Box 5065  
 Minot, ND 58702-5065

## ACKNOWLEDGEMENT IN LIEU OF ILLUSTRATION SUBMISSION

For use when no illustration is used during solicitation, when the policy applied for is different than as shown in the illustration used during solicitation or when a computer screen was used during solicitation.

**Definition of Illustration:** An illustration is any written or computer information that depicts the non-guaranteed values of a life insurance policy over a period of time greater than one year. For example, a document that shows non-guaranteed values as of age 65 would be an illustration.

I. **Applicant:** I acknowledge that: (please select one)

- No illustration was used in this solicitation
- The illustration(s) used in this solicitation did not conform to the policy applied for
- A computer screen was used in this solicitation and the information described below was displayed.

### INFORMATION DISPLAYED ON COMPUTER SCREEN

Name of insured: \_\_\_\_\_ Name of insured: \_\_\_\_\_  
 Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Underwriting Classification: \_\_\_\_\_  
 Generic name of policy: \_\_\_\_\_  
 Company product name: \_\_\_\_\_ Form #: \_\_\_\_\_  
 Generic name of rider(s): \_\_\_\_\_  
 Guaranteed interest rate: \_\_\_\_\_ Non-guaranteed interest rate: \_\_\_\_\_  
 Number of policy years illustrated: \_\_\_\_\_ Initial death benefit: \_\_\_\_\_  
 Premium amount illustrated is \$ \_\_\_\_\_ which is payable \_\_\_\_\_ (mode) for \_\_\_\_\_ (assumed number of years premiums will be paid)  
 Name of insurer: \_\_\_\_\_  
 Name and address of agent: \_\_\_\_\_

I understand that an illustration conforming to any policy issued in connection with this application will be provided to me on or before delivery of the policy.

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

II. **Agent:** I certify that: (please select one)

- No illustration was used in the solicitation of this application for insurance.
- The illustration(s) used in this solicitation did not conform to the policy applied for.
- A computer screen was displayed in this solicitation and that the information described above was displayed.

I have explained that any non-guaranteed elements of the policy are subject to change. I have made statements on non-guaranteed elements that are wholly consistent with the illustration that will be provided to the applicant at policy delivery.

Agent signature \_\_\_\_\_ Date \_\_\_\_\_

Agent number \_\_\_\_\_

# ING RETURN OF PREMIUM TERM LIFE INSURANCE SUPPLEMENT TO APPLICATION

ReliaStar Life Insurance Company, Minneapolis, MN  
 Administrative Office:  
 P.O. Box 5075  
 Minot, ND 58702-5075  
*A member of the ING family of companies*



Please complete the sections below and sign and submit this form with your original application for the ING Return of Premium Term Life Insurance Policy. The ING Return of Premium Term Life Insurance policy consists of a base term insurance policy and a Return of Premium Rider.

Proposed Insured Name \_\_\_\_\_

Owner Name (if other than Proposed Insured) \_\_\_\_\_

Writing Agent/Registered Rep. Name \_\_\_\_\_

## PRODUCT INFORMATION *(This section replaces the "Product Information" section of the Application for Life Insurance.)*

ING Return of Premium Term Life Insurance:  Basic Version  Enhanced Version

*The Basic Version will be assumed if no choice is made.*

Level Premium Period:  15 Year  20 Year  30 Year

Face Amount \$ \_\_\_\_\_

## AUTOMATIC PREMIUM LOAN (APL)

If you elect the APL Option, you direct ReliaStar Life Insurance Company (the "Company") to pay premiums due but not paid by the end of the grace period by taking a loan against any available Loan Value. If the available Loan Value is not sufficient to pay the premium then due, the policy may terminate.

I elect the Automatic Premium Loan (APL) Option

## LIST BILL INFORMATION

*For a new List Bill Plan, please contact the List Bill Department at 877-886-5050.*

List Bill/File Code # (if plan already exists) \_\_\_\_\_

Employer Plan Name (if plan already exists) \_\_\_\_\_

Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

*Street Address*

*City*

*State*

*ZIP*

## AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby acknowledge that this Supplement to Application is part of the application for the ING Return of Premium Term Life Insurance policy and authorize the Company to use the information obtained in this Supplement to Application to evaluate my eligibility for life insurance.

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Owner (if other than the Insured) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Writing Agent/Registered Rep. \_\_\_\_\_ Date \_\_\_\_\_