Request for Insurance and Payroll Deduction

RELIASTAR LIFE INSURANCE COMPANY (RELIASTAR)

THE NGAUS TECHNICIAN PROTECTION PROGRAM

Agreement

I request participation in the insurance plan offered by ReliaStar. I understand that, upon issuance, I will become a Member of the NGAUS Insurance Trust. I understand that my employer, as a service performed for me, will make regular payroll deductions for the premiums.

The information I have given on this application is furnished to obtain the insurance and is true and complete to the best of my knowledge and belief. I direct that all experience credits declared as a result of my participation in the NGAUS Insurance Trust, after payment of Trust expenses, shall be paid to the National Guard Association of the United States or The National Guard Educational Foundation, as determined by the NGAUS Insurance Trust. No obligation shall be incurred because of information furnished unless and until coverage is approved by ReliaStar and the first premium is paid in full.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates on information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its files. If you ask, MIB will arrange for disclosure of the information it has about you in its life. However, only the licensed physician you choose will be given medical information. If you feel the information in MIB's file is not correct, you may contact MIB and ask them to correct it as provided in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life of health insurance or to whom a claim benefits may be submitted.

Any person who, knowingly 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, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

THIS APPLICATION IS NOT APPLICABLE TO RESIDENTS OF SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, OHIO, OREGON AND PUERTO RICO

1. Please complete the information requested. Please print in ballpoint pen. Press firmly

Applicant's name (First, Middle Initial, Last)	Sex ❑ M ❑ F	Date of Birth month / day / year	Age	Social Security Number

Address	City	State Zip	Height ' "	Weight lbs.

Applicant's daytime phone number ( )	Location of pay office	Pay office phone number ( )	Pay office code

Employing office	Date of employment month / day / year	Job duty	Annual Salary

2. Fill out this section if you are applying for spouse coverage.

Spouse's name (First, Middle Initial, Last)	Date of Birth month / day / year	Height ' "	Weight lbs.	Social Security Number

Employer	Occupation

3. Select the coverage you want. ❑ New Application ❑ Change/add coverage

❑ **A. Term Life Insurance**

	Amount Coverage				
Technician	❑ $25,000	❑ $50,000	❑ $150,000	❑ $250,000	Other Amount: _____
Spouse	❑ $25,000	❑ $50,000	❑ $150,000	❑ $250,000	Other Amount: _____
Child(ren) per child	❑ $5,000	❑ $10,000			

❑ **B. Disability Income (Technician)**

Salary ❑ Under $18,000 ❑ $18,000 to $27,999 ❑ $28,000 to $31,999 ❑ $32,000 to $39,999 ❑ $40,000 to $49,999 ❑ $50,000 and over

❑ **C. Supplemental Disability Income (Technician) (must have Basic Disability)**

Salary ❑ Under $20,000 ❑ $20,000 to $23,999 ❑ $24,000 to $25,999 ❑ $26,000 to $31,999 ❑ $32,000 to $39,999 ❑ $40,000 to $49,999 ❑ 50,000 and over

Note: Coverages A, B & C do not require completion of the health questions if the Applicant applies for $25,000 or $50,000 within 31 days of the date of employment. (All Spouse coverage requires evidence of insurability)

FOR OFFICE USE ONLY - Deduction amount for above coverages

A. _____ _____ _____ B. _____ C. _____			1st payroll deduction
Deduction amount	Effective date month / day / year	Transmittal number HRO	Consec. no.

4. Complete if you want children's coverage.

List the names and birthdates of all unmarried dependent children, stepchildren, and legally adopted children age 14 days to age 19 (to age 25 if a full time student at an accredited educational institution).

First	Middle	Last	Date of Birth month / day / year
First	Middle	Last	Date of Birth month / day / year
First	Middle	Last	Date of Birth month / day / year

5. Name of Beneficiary for each life plan applied for. *(Name and Relationship)*

- Term Life (Technician) _____
- Term Life (Spouse) _____

Beneficiary of the Children's Coverage will be the insured parent.

6. Health Questions

(NOTE: The *Technician*, if applying for Group Term Life, Disability Income or Supplemental Disability Income, within 31 days of employment does not have to complete this section. If applying for these coverages *after* 31 days of employment or applying for Supplemental Term (coverage over $50,000), Technician must answer these health questions.

Spouse must always answer the health questions when applying for coverage.

In Minnesota, the applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. **Refer to the Authorization and Acknowledgement section for a definition of "Emergency Medical Personnel".**

	Technician		Spouse	
A. Have you had medical attention, consulted a physician or been hospitalized in the last 5 years?	❑ Yes	❑ No	❑ Yes	❑ No
B. At the present time are you under a doctor's care or taking medication for any condition?	❑ Yes	❑ No	❑ Yes	❑ No
C. In the last five years have you been diagnosed or treated by a physician for any of the following? Circle each specific condition: Lung disorder, high blood pressure, heart trouble, nervous disorder, ulcer, liver or stomach disorder, kidney or urinary disorder, diabetes, arthritis, back trouble, cancer, eye or ear impairment, any female disorder, or any physical defect or deformity?	❑ Yes	❑ No	❑ Yes	❑ No

For each "Yes" answer, give details below: *(If necessary, please attach additional sheet signed and date by Technician and Spouse if applying).*

Nature of illness, injury or treatment	Person to whom it applies	Date of treatment	Physician's name and address

7. Please Read and Sign

Authorization and Acknowledgement

For underwriting purposes, I give my permission to:

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

LIMITATIONS, if any:

I understand all or part of this information may be sent to MIB, Inc. It may also be made available to any ReliaStar reinsurer, employee. or contractor who processes transactions that concern any insurance I may have applied for or have with ReliaStar.

I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations-42CFR Part 2. I give my permission to ReliStar 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 may revoke this authorization as it applies to any information protected by this Federal Regulation at any time, but not to the extent action has been taken in reliance on it.

In Minnesota, this authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term **"emergency medical personnel"** includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squads personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota Security Hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

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. As it relates to the incontestability clause, this form is valid for two years from the date of coverage. For all other purposes, including collecting information in connection with this application, reinstatement and requests for change in benefits, this form is valid for one year or until coverage terminates, whichever is earlier.

I acknowledge that I have read the notice regarding MIB on the front side of this application.

X	X	X	X
Technician's Signature *(if applying)*	Today's Date *(Mo./Day/Yr.)*	Spouse's Signature *(if applying)*	Today's Date *(Mo./Day/Yr.)*

WHITE – Original-ReliaStar CANARY – Payroll Office PINK – HRO GOLD – Retain For Your Records

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. 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, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. 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 us. 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; or your state's Insurance Information and Privacy Protection Act, if any. 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. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

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