Request for Insurance and Payroll Deduction

RELIASTAR LIFE INSURANCE COMPANY (RELIASTAR)

THE NGAUS TECHNICIAN PROTECTION PROGRAM

Agreement

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 understand that my employer, as a service performed for me, will make regular payroll deductions for the premiums. No obligation shall be incurred because of information furnished unless and until coverage is approved by ReliaStar Life 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 an 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 file. 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 mailing address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. The phone number is 866-692-6901 and the fax number is 866-346-3642. The MIB website address is www.mib.com. 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 for 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 FOR USE ONLY IN OHIO, SOUTH CAROLINA, TEXAS AND SOUTH DAKOTA.

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

Applicant's Name (First, Middle Initial, Last)		Sex ❑ M ❑ F	Birth Date 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)	Birth Date 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 to $59,999 ❑ $60,000 to $74,999 ❑ $75,000 to $89,999 ❑ $90,000 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 to $59,999 ❑ $60,000 to $74,999 ❑ $75,000 to $89,999 ❑ $90,000 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.)

Is this insurance intended to replace, discontinue or change any life insurance or annuities you now have in force?
❑ Yes ❑ No *(If "yes," give details at right.)*

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. Number

4. Complete if you want children's coverage.

List the names and birth dates 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	Birth Date month / day / year
First	Middle	Last	Birth Date month / day / year
First	Middle	Last	Birth Date 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 *Applicant*, 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.

		Applicant		Spouse	
A.	Do you have any impairment in health or physical condition?	❑ Yes	❑ No	❑ Yes	❑ No
B.	Have you had medical attention, consulted a physician or been hospitalized in the last 5 years?	❑ Yes	❑ No	❑ Yes	❑ No
C.	At the present time are you under a doctor's care or taking medication for any condition?	❑ Yes	❑ No	❑ Yes	❑ No
D.	Have you ever had or been told by a physician you had any of the following?	❑ Yes	❑ No	❑ Yes	❑ No

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?

For each "Yes" answer, give details below: *(If necessary, please attach additional sheet signed and date by Applicant 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, Medical Information Bureau, Inc. (MIB), Department of Motor Vehicle Records or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its agents, employees and authorized representatives (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 or non-medical information regarding motor vehicle or criminal records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons. Upon your request, you may be interviewed in connection with the preparation of the report and receive a copy of the report.

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, or my authorized representative, have the right to get a copy of this form. A photocopy of this form will be as valid as the original. For the purpose of collecting information in connection with this application, this authorization is valid for 30 months from the date shown below.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

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

Original to ReliaStar Insurance Co. - One Copy to Payroll Office - One Copy to HRO - One Copy to Retain for your records

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies

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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We or our reinsurers 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 an 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 file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files 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.