HOW TO APPLY

1. Complete the Request for Insurance. Please be sure to answer all questions fully to avoid unnecessary delays. The NATIONAL GUARD STATUS question is especially important to your Association.
2. You need send no money now. Simply complete and sign the Request for Insurance, and mail it in the enclosed postage-paid envelope.
3. After your Request has been approved, you will be sent an individual insurance certificate and a bill for the first premium. This material is intended to summarize the NGAUS Term Life Insurance Plan. The complete terms of coverage are governed by the policy.

NGAUS Insurance Trust

GROUP TERM LIFE INSURANCE

Name ____________________

Street Address ____________________

City ____________ State ________ ZIP ____________

Member and/or Spouse Coverage

REQUEST FOR INSURANCE

from ReliaStar Life Insurance Company

1. *Please complete the following information.*

Rank:

Social Security Number: Member *(if applying)* | Spouse *(if applying)*

What is your current status? ❒ AGR ❒ Tech ❒ M-Day

Spouse Name:

Are you currently a member of the National Guard Association of the United States? ❒ Yes ❒ No

Phone *(daytime)*: ( )

2. *Please indicate the amount of coverage you want.*

Member $ ____________ Spouse $ ____________

(If you are under age 60, $10,000 to $250,000 in $10,000 increments. If you are 60-64, $5,000 to $125,000 in $5,000 increments.)

Are you actively at work? Member ❒ Yes ❒ No If "no," reason ____________ Spouse ❒ Yes ❒ No If "no," reason ____________

3. *Please name your beneficiary.*

Member Beneficiary ____________ (First M.I. Last Name) Relationship ____________

Spouse Beneficiary ____________ (First M.I. Last Name) Relationship ____________

Children's beneficiary is always the insured parent.

4. *Check here if you want Children's Life Insurance.*

Children age 14 days to 19 years; or to age 25 if a full-time student.

Children's Names & Dates of Birth:

Member: ❒ $10,000 each child ❒ $5,000 each child ❒ $2,000 each child

Spouse: ❒ $10,000 each child ____________ ❒ $5,000 each child ____________ ❒ $2,000 each child ____________

If over 19 years of age, please indicate if full-time student. ____________

5. *Please complete the Personal Information and Medical Data.*

Member *(if applying)*: Date of Birth (Mo. Day Yr.) | Present Height (Ft. In.) | Present Weight (lbs.)

Spouse *(if applying)*: Date of Birth (Mo. Day Yr.) | Present Height (Ft. In.) | Present Weight (lbs.)

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 policy; (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 Acknowledgment section for a definition of "Emergency Medical Personnel".**

	Member Coverage	Spouse Coverage
1. Have you ever had heart trouble, high blood pressure, chest pains, albumin or sugar in urine, tuberculosis, cancer, tumor, or ulcers, or any other health impairments?	❒ Yes ❒ No	❒ Yes ❒ No
2. Have you had any medical advice or treatment during the past three years for illness, injury or surgery?	❒ Yes ❒ No	❒ Yes ❒ No
3. At the present time are you under a doctor's care or taking medication for any condition?	❒ Yes ❒ No	❒ Yes ❒ No

Any person who knowingly and with the intent to defraud submits an application or files a statement of claim containing any materially false or misleading information commits a fraudulent act which is a crime.

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

Please complete reverse side ➤

For each "Yes" answer, please complete all information below. If needed, attach an additional sheet signed and dated.					
Question #	Name of family member	Nature of illness or injury and type of treatment	Results and degree of recovery	Date of treatment	Physician's name and complete address *(include your medical or clinic I.D. number if any.)*

I want to pay the premium: ❒ Quarterly ❒ Semi-annually ❒ Annually

6.

Please read the agreement and sign below.

AGREEMENT

The information I have given above 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 Life Insurance Company and the first premium is paid in full.**

AUTHORIZATION AND ACKNOWLEDGMENT

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 ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, or surgery.

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 Life Insurance Company reinsurer, employee, or contractor who processes transactions that concern any insurance I may have applied for or have with ReliaStar Life Insurance Company.

I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42CFR Part 2. I give permission to ReliaStar Life Insurance Company to get any and all such information for the purposes described in this form. I specifically consent to the re-disclosure 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 squad 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 receive 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 I have a right to get a copy of this form. A photocopy of this form will be a valid as the original. This form will be valid for 26 months from the date shown below or for 2 years from the date the policy is issued, whichever is earlier.

I acknowledge that I have been given ReliaStar Life Insurance Company Consumer Privacy Notice and Notice Regarding MIB, Inc.

Send no money now. You will be billed later.

Send complete application to: NGAUS Insurance Plans, One Massachusetts Avenue NW, Washington DC 20001

Member's Signature *(if applying)* X	Today's Date / / month day year
Spouse's Signature *(if applying)* X	Today's Date / / month day year