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. 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 certifi - cate and a bill for the fi rst 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 # 91004-0

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 _____ Relationship _____
First M.I. Last Name

Spouse Beneficiary _____ Relationship _____
First M.I. Last Name

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.

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

Children's Names & Dates of Birth:
_____
_____
_____

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

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.

Notice Regarding MIB, Inc.
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.