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 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 for benefits may be submitted.

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 FOR USE ONLY IN OHIO, SOUTH CAROLINA, TEXAS AND SOUTH DAKOTA.

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.)

Is this insurance intended to replace 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. 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 Name	Date of Birth month / day / year
First	Middle	Last Name	Date of Birth month / day / year
First	Middle	Last Name	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 *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), Applicant 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? 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 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, 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 ReliaStar 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.

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 a right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for 30 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 read the notice regarding MIB on the front side of this application.

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.)*