ReliaStar Life Insurance Company

Home Office:
PO Box 20, Minneapolis, MN 55440
Administrative Office:
PO Box 122, Minneapolis, MN 55440-0122

Critical Illness Insurance Application – Cancer Plan

Type of Enrollment / Change: *(check all that apply)*

___ Initial Enrollment ___ Increase ___ Late Entrant** ___ Reinstatement
___ Regular Enrollee* (New Hire) ___ Re-Enrollment ___ Other__________

Regular Enrollee* A regular enrollee is a new employee / member enrolling in the plan at the first available opportunity.

Late Entrant** A late entrant is an individual who is enrolling into the plan after the first available opportunity.

Home Office Use Only

Group Number	Employee / Member Certificate Number	Spouse Certificate Number

Section 1. Employee / Member Information

Name of Group Policyholder

Employee / Member Name *(first, middle initial, last)*	☐ Female ☐ Male	Date of Birth ________ *(Month, Day, Year)*	Age as of Proposed Effective Date
Employee / Member Home Address *(street address, city, state, ZIP)*			Phone Number Work ________ Home ________

Department # ________	Location # ________	Pay Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other:________	Employee / Member ID # ________

Job Title or Occupation	Employee/Member Class	Basic Monthly Salary $	Date of Hire ________ *(Month, Day, Year)*	Social Security # ____ ____ ____

Employment Status: I am Actively At Work ☐ Yes ☐ No	I Am Scheduled to Work ________ Hours Per Week

Section 2. Proposed Insured Information for Employee / Member

Has the Proposed Insured used tobacco in any form in the last 24 months? ☐ Yes ☐ No		
Riders ☐ Child(ren's) Critical Illness Rider	Coverage Amount $________	Total Monthly Premium Amount $________

Section 3. Proposed Insured Information for Spouse/California Registered Domestic Partner (Complete only if applying for spouse coverage.)

Name	☐ Female ☐ Male	Date of Birth ________ *(Month, Day, Year)*	Age as of Proposed Effective Date
Has the Proposed Insured used tobacco in any form in the last 24 months? ☐ Yes ☐ No			
Riders ☐ Child(ren's) Critical Illness Rider	Coverage Amount $________	Total Monthly Premium Amount $________	

Section 4. Child(ren) Information (Complete only if applying for Child(ren's) Critical Illness Rider.)

Child Name	Date of Birth	Gender
Child Name #1 *(first, middle initial, last)*	Date of Birth ________ *(Month, Day, Year)*	☐ Female ☐ Male
Child Name #2 *(first, middle initial, last)*	Date of Birth ________ *(Month, Day, Year)*	☐ Female ☐ Male
Child Name #3 *(first, middle initial, last)*	Date of Birth ________ *(Month, Day, Year)*	☐ Female ☐ Male
Child Name #4 *(first, middle initial, last)*	Date of Birth ________ *(Month, Day, Year)*	☐ Female ☐ Male

Employee Name: ______________________________ SSN: ________________________________

Child Name #5	Date of Birth	☐ Female ☐ Male
Child Name #6	Date of Birth	☐ Female ☐ Male
Child Name #7	Date of Birth	☐ Female ☐ Male
Child Name #8	Date of Birth	☐ Female ☐ Male
Child Name #9	Date of Birth	☐ Female ☐ Male
Child Name #10	Date of Birth	☐ Female ☐ Male
Child Name #11	Date of Birth	☐ Female ☐ Male
Child Name #12	Date of Birth	☐ Female ☐ Male
Child Name #13	Date of Birth	☐ Female ☐ Male
Child Name #14	Date of Birth	☐ Female ☐ Male
Child Name #15	Date of Birth	☐ Female ☐ Male
Child Name #16	Date of Birth	☐ Female ☐ Male
Child Name #17	Date of Birth	☐ Female ☐ Male
Child Name #18	Date of Birth	☐ Female ☐ Male
Child Name #19	Date of Birth	☐ Female ☐ Male

Section 5. Simplified Issue Underwriting	Employee/ Member	Spouse	Child #1	Child #2	Child #3	Child #4
1.) Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS – related complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.) In the past 10 years, have you been diagnosed with or sought medical treatment (including medication) for cancer (other than basal cell or squamous cell carcinoma of the skin), and/or brain tumor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3.) Have you been recommended by any member of the medical profession to have diagnostic tests for cancer which have not yet been performed or for which results have not yet been received (excluding routine periodic mammogram, pap smears, colonoscopies and/or PSA tests)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.) Do each of the proposed insured's listed in Section 2 or 3 have comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? (If "No", persons without comprehensive health coverage are not eligible for this coverage.)	☐ Yes ☐ No	☐ Yes ☐ No				

Section 6. Above Simplified Issue Underwriting	Employee / Member	Spouse
1.) **Employee/Member:** Height __________ft. ___________in. Weight ____________lbs **Spouse:** Height __________ft. ___________in. Weight ____________lbs **Agent/Producer:** Does the height and weight exceed the maximum shown on the chart provided?	☐ Yes ☐ No	☐ Yes ☐ No
2.) Have any TWO (2) or more of your natural parents or natural siblings (sisters or brothers) been diagnosed with cancer, other than basal cell or squamous cell carcinoma of the skin, prior to age 60?	☐ Yes ☐ No	☐ Yes ☐ No

Section 7. Replacement Information	Employee / Member	Spouse
1. Do you have any existing Critical Illness or Specified Disease policies or contracts? (If Yes, complete question 2 below.) Current Carrier ____ Coverage Amount ____________________	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you considering discontinuing making premium payments, surrendering, forfeiting, or otherwise terminating your existing policy or contract?	☐ Yes ☐ No	☐ Yes ☐ No
3. **Agent/Producer:** To the best of your knowledge, does this coverage replace any existing coverage?	☐ Yes ☐ No	☐ Yes ☐ No

Remarks or Special Requests

FRAUD WARNING STATEMENT

Arkansas, Louisiana, Maine, New Mexico, Ohio, Oklahoma, Tennessee, Washington, West Virginia: 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and 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.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

Insurance benefits are contingent on proof of loss. Benefits may require medical information from your health care provider.

ReliaStar Life Insurance Company reserves the right to withdraw the plan if participation during the initial enrollment is less than [25] covered Certificateholders or any other state specific participation requirements. It is understood and agreed that this application shall be made a part of the policy applied for and that no insurance shall be effective until approved by the company at its home office.

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my insurance coverage purchased through *ReliaStar Life Insurance Company*. This authorization and assignment will remain in effect until revoked by me in writing to my Employer.

Read the section above and then sign and date below.

Proposed Effective Date of Certificate OR Date of Change: _______________ *(Month, Day, Year)*

Provided you are actively at work, the actual Certificate Effective Date will be determined by the latest of the following:

(i) the date the completed application is submitted to and accepted by ReliaStar Life Insurance Company;

(ii) the date satisfactory evidence of insurability is received, if required;

(iii) the date the premium payment has been received.

Amendments, Corrections, and Notations (HO Use Only):

Employee / Member Signature:	Signed at *(City & State):*	On *(Month, Day, Year):*
Agent / Producer Signature:	Signed at *(City & State):*	On *(Month, Day, Year):*