GUARANTEED ISSUE
CRITICAL ILLNESS INSURANCE APPLICATION (CA)

ReliaStar Life Insurance Company, Minneapolis, MN
Administrative Office: PO Box 20, Minneapolis, MN 55440

PLAN INFORMATION

Group Policyholder Name _____

Group Number _____

ENROLLMENT TYPE

☐ Initial Enrollment ☐ Increase ☐ Late Entrant[2]
☐ Regular Enrollee[1] (New Hire) ☐ Re-Enrollment ☐ Special Enrollment ☐ Other _____

[1]*A regular enrollee is a new employee applying at the first available opportunity.*
[2]*A late entrant is an employee applying after the first available opportunity, with the exception of special enrollment offers.*

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____

Birth Date *(Month, Day, Year)* _____ Social Security # _____ Gender: ☐ Female ☐ Male

E-mail Address _____

Residence Address _____ City _____ State _____ ZIP _____

Residence or Cell Phone _____ _____ Work Phone _____ _____

Proposed Effective Date of Coverage OR Date of Change *(Month, Day, Year)* _____ Age on Proposed Effective Date _____

Hire Date *(Month, Day, Year)* _____ Job Title / Occupation _____

Employee ID # _____ Employee Class _____

Is the Employee Actively At Work? ☐ Yes ☐ No The Employee is Scheduled to Work _____ Hours Per Week

Pay Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Department # _____ Location # _____

COVERAGE REQUESTED

Does each person to be insured have comprehensive health benefits from an insurance policy, an HMO Plan, or an employer health benefit plan?
(If "No," that person is not eligible for this coverage.) ☐ Yes ☐ No

Employee: Requested Benefit Amount / Coverage Amount: *(check one)* ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

Note: Employee coverage is required in order to apply for the Spouse and Children's Riders.

☐ Spouse Critical Illness Rider: Requested Benefit Amount / Coverage Amount: *(check one)* ☐ $5,000 ☐ $10,000

☐ Children's Critical Illness Rider:
Requested Benefit Amount / Coverage Amount: *(check one)* ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000

SPOUSE/CALIFORNIA REGISTERED DOMESTIC PARTNER INFORMATION *(Complete only if applying for Spouse Critical Illness Rider.)*

Name *(First, Middle Initial, Last)* _____ Gender: ☐ Female ☐ Male

Birth Date *(Month, Day, Year)* _____ Age on Proposed Effective Date _____

ACKNOWLEDGMENTS AND AUTHORIZATIONS

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 Employees or any other state specific participation requirements. It is understood and agreed that this application shall be made a part of the coverage applied for and that no insurance shall be effective until approved by the company at its home office, regardless of when the first premium is paid.

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. I understand that my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am in active employment.

This application is part of the Policy and subject to the terms and conditions of the Policy. I understand that no agent, representative or employee of ReliaStar Life Insurance Company, my Employer or any other entity may change or waive the requirements of this application, or the terms of the Policy, the Certificate or any riders, except as specifically set forth in the Policy.

➥ Employee Signature _____ Date _____

Signed At *(City & State)* _____