

# Affinity<sup>®</sup> Yearly Renewable Term Life Application

Members and their spouses or domestic partners can apply for this coverage. Each applicant should complete a separate application. *Please print clearly in dark ink and mail in the envelope provided.* Affinity 2000

**1** TELL US ABOUT YOURSELF

Name of Association:

Are you applying as:  Association Member  Spouse/Domestic Partner of Member

YOUR NAME ( <i>last, first, middle</i> )			<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE
DATE OF BIRTH	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER	
STREET ADDRESS				
CITY		STATE	ZIP	
HOME PHONE ( )		WORK PHONE ( )		

Owner (if other than yourself). *The owner controls all rights to this policy.*

NAME	STREET		
CITY	STATE	ZIP	

- If you are a **new** applicant, indicate *initial* amount of coverage applied for: \$ \_\_\_\_\_ in \$10,000 increments
- If you are **increasing** coverage, indicate amount of *additional* coverage applied for with this application: \$ \_\_\_\_\_ in \$10,000 increments
- Optional coverages
  - Accidental Death Benefit
  - Disability Waiver of Premium
  - Children's Insurance Rider: \$10,000 on each child
- Have you used tobacco products of any kind in the last 12 months?  YES  NO
- Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?  YES  NO  
*If yes, please explain:* \_\_\_\_\_
- Are you currently working at least 30 hours per week at your regular occupation and place of business?  YES  NO

**2** BENEFICIARY INFORMATION

List one or more beneficiaries below. Beneficiaries may include your spouse, domestic partner, children, parents, charities or anyone you wish. List the percent each will receive. The total must equal 100 percent.

NAME	ADDRESS	RELATIONSHIP	PERCENT

**3** PROVIDE US WITH THIS HEALTH INFORMATION

a. Have you, for any condition during the past 12 months, been diagnosed or treated by a member of the medical profession, received surgical care, or taken prescribed medication?	YES	NO
b. Have you been diagnosed or treated by a member of the medical profession in the past 10 years for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you been diagnosed or treated by a member of the medical profession in the past 10 years for nervous, brain or lung disorders, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury, or other disease or disorder?	<input type="checkbox"/>	<input type="checkbox"/>

*Please complete and sign the back of application.*

- d. Have you ever sought help or received counseling or treatment for depression, alcohol or drug use, or are you currently using illegal drugs? In the past 10 years have you received professional treatment for an anxiety disorder? YES NO
- e. Have you ever applied for insurance that was declined, postponed or modified in any way?
- f. **If you answered "yes" to any of the questions above, please give details below and on additional sheets if needed.**

NATURE OF ILLNESS, INJURY OR OPERATION	DATE(S) OF TREATMENT	REMAINING EFFECTS	NAME AND ADDRESS OF DOCTORS AND HOSPITALS

g. List the name and address of your regular physician and the date you last consulted him or her:

**If you are applying for SUPER-PREFERRED RATES, please fill out questions h, i, j and k.**

h. Has your mother, father, or any sister or brother died prior to age 70 as a result of heart disorder, stroke, or cancer?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
i. Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?	<input type="checkbox"/>	<input type="checkbox"/>
j. Have you used tobacco or nicotine in any form in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
k. Have you in the last three years had any motor vehicle accidents, DUI convictions (driving under the influence) or other moving violations? Please provide your driver's license number: _____	<input type="checkbox"/>	<input type="checkbox"/>

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READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid during my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

**Authorization and Acknowledgment** – Please read and sign below.

For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life 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 know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

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 the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 24 months from the date shown below.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

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

YOUR SIGNATURE	DATE SIGNED	SIGNATURE OF OWNER (if other than yourself)	DATE SIGNED
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ADMINISTRATOR USE ONLY	Group Number	Ass'n Name	Signature of Licensed Ins. Rep.	
HOME OFFICE USE ONLY	Premium Received with Application	Effective Date	Policy Number	

Super-Preferred Application  Yes  No