Group Level Term Life Insurance

Underwritten by ReliaStar Insurance Company

Benefits Guide for COA Members

Questions?

800.775.2020

Email:

COA.Insurance.service@getamba.com

AMBA

Lock In Solid Benefits for a full 10 or 20 Years

With benefits ranging from $200,000 to $1 million (in increments of $50,000), you can help build a strong financial safety net for your family with the Group 10-Year and 20-Year Level Term Life Insurance Plan.

Level Life Benefits for You and Your Spouse

As a member age 65 or under, you can request benefits for yourself, and your spouse age 65 or under, if not legally divorced or separated from you. (Applicant must be age 55 or under at the time the policy is issued to qualify for a 20-year level term rate period.)

This is important coverage when you consider that many families rely on two incomes these days. All your unmarried, dependent children ages 14 days to under 19 years (25 if full-time student) also qualify for coverage.

Collect a Portion of Your Benefits if Terminally Ill

This important plan option gives you the ability to collect part of your Group Level Term Life benefits before your death if you are diagnosed with a terminal illness. If your doctor diagnoses you with a life expectancy of 12 months or less, you can collect up to 50 percent of your benefits (or $250,000, whichever is less) before you die — to use however you wish. Receipt of accelerated payments may be taxable. Assistance should be sought from a personal tax advisor.

(Note: A doctor-certified terminal illness means an illness from which no recovery is expected, that results in a life expectancy of 12 months or less.)

Collect Double Benefits for Accidental Death & Dismemberment

You may also add Group Accidental Death & Dismemberment (AD&D) benefits to your life insurance coverage. If added, the AD&D benefit amount will match the life insurance benefit amount to a maximum of $500,000. In addition, if you are seriously injured in a covered accident and sustain loss of limb, eyesight or other injuries, a partial benefit may be payable.

When Your Coverage Starts

Your and your spouse's insurance will become effective, subject to timely payment of premium, on the first of the month following the later of the date:

- ReliaStar Life approves your and your spouse's proof of good health;
- You and your spouse become eligible for insurance; or
- You and your spouse apply for insurance, if proof of good health is not required.
- Spouse's coverage cannot exceed member's coverage.

You Choose Your Beneficiary

You may name anyone you wish as the beneficiary of this plan, and you may change the beneficiary by contacting the Insurance Administrator in writing and advising them of the change. You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

Covered 365 Days a Year

No matter where you are, this plan covers you. The only exclusion is suicide, while sane or insane, within the first two years of the date your insurance or increase in insurance starts. The Accelerated Life and AD&D benefits are subject to additional exclusions.

If suicide occurs during the two year time period, ReliaStar Life will refund only the amount of premiums paid for your insurance or increase in insurance under the Group Policy. ReliaStar Life will not pay a death benefit.

When Your Coverage Ends

As long as you remain an active member, pay your premium when due, and the Group Policy remains in force, you can keep your coverage. At the end of a level term period, coverage can be continued under a five-year age bracketed rate plan if unable to re-qualify for a new 10-year or 20-year level term rate period. If you are no longer covered under the 10 or 20 year level term plan, your coverage will reduce to 50% at age 70. Coverage terminates at age 75.

Your insurance stops on the earliest of the following dates:

- The last day of the quarter during which you are no longer eligible for insurance under the Group Policy.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.
- The date the Group Policy terminates.
- The premium due date on or after your 75th birthday.
- The date the Trust agreement establishing the Life Insurance Trust terminates.
- For Accelerated Life Benefit, the date your life insurance stops.
- For AD&D Insurance, the date your life insurance stops.

PLEASE KEEP FOR YOUR RECORDS

All members and spouses must complete an application form for any new coverage or to increase coverage (including dependent coverage) or to begin an initial or subsequent 10-year or 20-year Level Term Rate Period when proof of good health is required. Some applicants may be required to have a medical exam in order to apply for coverage. For more information on medical requirements, please contact your Plan Administrator. If there is an increase in the amount of your insurance, the increase will take effect on the first day of the month on or next following the date of the increase. If you are in a Level Term Rate Period, premiums for the increased amount of insurance will be based on your attained age on the effective date of the increase. Your Group Level Term Life Plan will start on the first day of the month after your application has been accepted and your first premium has been paid.

Quarterly Rates (Rates shown are as of June 1, 2023)

YOUR RATE IS THE RATE FOR YOUR AGE AT THE TIME COVERAGE IS ISSUED.

GROUP RATES

California Optometric Association
Tobacco User, Nontobacco Preferred and Nontobacco Super-Preferred Class
10 Years Quarterly Level Premium Rates per $1,000 Without Waiver

Note: Level Premium Rates apply to both Member & Spouse

	Volume Band: $200,000 through $499,999						Volume Band: $500,000 through $1,000,000					
Issue Age	Tobacco	Male NT-Preferred	NT-Super Preferred	Tobacco	Female NT-Preferred	NT-Super Preferred	Tobacco	Male NT-Preferred	NT-Super Preferred	Tobacco	Female NT-Preferred	NT-Super Preferred
18-26	0.344	0.148	0.122	0.228	0.131	0.108	0.319	0.143	0.118	0.203	0.125	0.105
27	0.348	0.152	0.122	0.239	0.135	0.108	0.325	0.144	0.118	0.215	0.129	0.105
28	0.357	0.152	0.122	0.253	0.135	0.108	0.334	0.144	0.118	0.228	0.129	0.105
29	0.372	0.152	0.125	0.268	0.135	0.108	0.348	0.144	0.118	0.243	0.129	0.105
30	0.390	0.152	0.125	0.287	0.135	0.108	0.365	0.144	0.118	0.262	0.129	0.105
31	0.410	0.156	0.125	0.306	0.135	0.108	0.388	0.148	0.118	0.283	0.129	0.105
32	0.437	0.156	0.125	0.331	0.135	0.108	0.412	0.148	0.118	0.306	0.129	0.105
33	0.467	0.156	0.129	0.357	0.135	0.108	0.443	0.148	0.122	0.333	0.129	0.105
34	0.500	0.158	0.129	0.386	0.135	0.108	0.475	0.152	0.122	0.363	0.129	0.105
35	0.538	0.158	0.129	0.418	0.135	0.112	0.515	0.152	0.122	0.395	0.129	0.108
36	0.580	0.158	0.129	0.456	0.139	0.112	0.557	0.152	0.122	0.431	0.131	0.108
37	0.625	0.162	0.129	0.494	0.143	0.116	0.602	0.156	0.122	0.469	0.135	0.112
38	0.678	0.162	0.139	0.536	0.156	0.125	0.654	0.156	0.131	0.511	0.148	0.118
39	0.735	0.171	0.150	0.578	0.165	0.139	0.711	0.165	0.135	0.553	0.158	0.131
40	0.798	0.179	0.156	0.621	0.179	0.144	0.773	0.171	0.148	0.597	0.171	0.139
41	0.870	0.215	0.167	0.665	0.194	0.158	0.846	0.205	0.162	0.640	0.188	0.152
42	0.948	0.238	0.188	0.711	0.211	0.171	0.923	0.228	0.181	0.686	0.201	0.165
43	1.032	0.255	0.205	0.758	0.234	0.188	1.007	0.245	0.198	0.733	0.224	0.181
44	1.117	0.283	0.224	0.806	0.255	0.205	1.093	0.274	0.215	0.783	0.245	0.198
45	1.229	0.308	0.255	0.882	0.274	0.220	1.191	0.295	0.245	0.844	0.264	0.211
46	1.317	0.336	0.270	0.931	0.291	0.238	1.281	0.323	0.260	0.893	0.277	0.228
47	1.404	0.380	0.296	0.980	0.317	0.255	1.368	0.363	0.283	0.942	0.304	0.245
48	1.499	0.412	0.321	1.034	0.336	0.270	1.461	0.397	0.308	0.996	0.323	0.260
49	1.606	0.452	0.350	1.091	0.353	0.287	1.568	0.435	0.336	1.053	0.340	0.277
50	1.723	0.502	0.384	1.151	0.384	0.304	1.685	0.483	0.367	1.113	0.367	0.291
51	1.839	0.551	0.422	1.208	0.410	0.331	1.801	0.528	0.407	1.170	0.393	0.317
52	1.963	0.600	0.469	1.267	0.439	0.359	1.925	0.578	0.448	1.229	0.422	0.346
53	2.096	0.663	0.519	1.330	0.469	0.386	2.060	0.631	0.498	1.292	0.448	0.371
54	2.240	0.720	0.576	1.398	0.505	0.422	2.204	0.690	0.551	1.362	0.486	0.407
55	2.390	0.792	0.635	1.471	0.542	0.456	2.354	0.760	0.608	1.435	0.519	0.435
56	2.537	0.866	0.697	1.547	0.585	0.486	2.500	0.832	0.671	1.511	0.562	0.466
57	2.689	0.935	0.760	1.626	0.625	0.515	2.654	0.899	0.730	1.590	0.599	0.496
58	2.871	1.028	0.836	1.714	0.676	0.555	2.835	0.988	0.804	1.678	0.652	0.532
59	3.103	1.127	0.918	1.811	0.733	0.587	3.067	1.081	0.882	1.777	0.703	0.564
60	3.380	1.246	1.018	1.911	0.783	0.638	3.346	1.197	0.979	1.877	0.752	0.612
61	3.799	1.797	1.167	2.157	0.978	0.659	3.926	1.708	1.093	2.067	0.942	0.810
62	4.386	1.958	1.265	2.296	1.028	0.691	4.350	1.871	1.192	2.260	0.994	0.916
63	4.874	2.159	1.390	2.460	1.093	0.734	4.838	2.074	1.318	2.423	1.062	1.002
64	5.443	2.387	1.535	2.663	1.174	0.788	5.406	2.304	1.465	2.628	1.142	1.057
65	6.095	2.728	1.754	2.906	1.304	0.874	6.058	2.649	1.684	2.870	1.272	1.185

PLEASE SEE IMPORTANT DISCLOSURES ON PAGE 4.

Quarterly Rates (Rates shown are as of June 1, 2023)

YOUR RATE IS THE RATE FOR YOUR AGE AT THE TIME COVERAGE IS ISSUED.

GROUP RATES

California Optometric Association
Tobacco User, Nontobacco Preferred and Nontobacco Super-Preferred Class
20 Years Quarterly Level Premium Rates per $1,000 Without Waiver

Note: Level Premium Rates apply to both Member & Spouse

	Volume Band: $200,000 through $499,999						Volume Band: $500,000 through $1,000,000					
Issue Age	Tobacco	Male NT-Preferred	NT-Super Preferred	Tobacco	Female NT-Preferred	NT-Super Preferred	Tobacco	Male NT-Preferred	NT-Super Preferred	Tobacco	Female NT-Preferred	NT-Super Preferred
18-26	0.393	0.168	0.132	0.281	0.155	0.119	0.376	0.172	0.139	0.264	0.130	0.128
27	0.409	0.179	0.135	0.300	0.165	0.123	0.393	0.179	0.142	0.284	0.168	0.132
28	0.433	0.181	0.139	0.327	0.168	0.125	0.413	0.181	0.145	0.307	0.172	0.135
29	0.459	0.188	0.145	0.351	0.172	0.128	0.443	0.188	0.148	0.333	0.172	0.135
30	0.492	0.192	0.148	0.380	0.172	0.128	0.472	0.192	0.152	0.360	0.176	0.139
31	0.529	0.199	0.152	0.409	0.175	0.132	0.509	0.199	0.155	0.393	0.176	0.139
32	0.572	0.201	0.155	0.443	0.175	0.132	0.552	0.201	0.159	0.427	0.179	0.142
33	0.618	0.205	0.162	0.483	0.179	0.135	0.599	0.205	0.165	0.463	0.179	0.142
34	0.671	0.211	0.165	0.523	0.179	0.135	0.651	0.211	0.168	0.503	0.179	0.142
35	0.731	0.215	0.168	0.565	0.179	0.142	0.713	0.215	0.168	0.548	0.179	0.148
36	0.796	0.218	0.172	0.615	0.185	0.142	0.777	0.218	0.172	0.595	0.181	0.148
37	0.866	0.228	0.175	0.664	0.188	0.145	0.849	0.224	0.175	0.644	0.188	0.152
38	0.945	0.231	0.192	0.720	0.208	0.162	0.929	0.228	0.192	0.701	0.205	0.162
39	1.035	0.248	0.199	0.777	0.221	0.179	1.010	0.244	0.199	0.757	0.221	0.181
40	1.131	0.257	0.218	0.840	0.241	0.188	1.111	0.257	0.221	0.820	0.241	0.192
41	1.233	0.314	0.241	0.903	0.264	0.208	1.216	0.307	0.241	0.883	0.264	0.211
42	1.345	0.351	0.271	0.972	0.291	0.228	1.329	0.344	0.275	0.952	0.284	0.231
43	1.468	0.376	0.297	1.041	0.324	0.255	1.448	0.373	0.300	1.025	0.320	0.258
44	1.600	0.427	0.331	1.117	0.357	0.281	1.580	0.420	0.327	1.101	0.353	0.285
45	1.758	0.459	0.371	1.216	0.380	0.297	1.729	0.453	0.373	1.190	0.380	0.301
46	1.904	0.509	0.400	1.299	0.409	0.324	1.874	0.503	0.403	1.273	0.407	0.328
47	2.214	0.581	0.447	1.385	0.453	0.353	2.024	0.572	0.447	1.356	0.449	0.357
48	2.214	0.641	0.489	1.474	0.489	0.380	2.189	0.631	0.489	1.445	0.485	0.387
49	2.397	0.724	0.548	1.570	0.529	0.416	2.370	0.713	0.552	1.540	0.525	0.423
50	2.598	0.813	0.612	1.673	0.581	0.447	2.569	0.800	0.608	1.643	0.575	0.449
51	2.920	1.173	0.701	1.889	0.726	0.461	3.013	1.141	0.679	1.808	0.720	0.595
52	3.370	1.277	0.761	2.010	0.763	0.483	3.339	1.250	0.740	1.977	0.759	0.673
53	3.744	1.407	0.835	2.152	0.812	0.513	3.713	1.385	0.819	2.119	0.811	0.736
54	4.182	1.556	0.922	2.331	0.872	0.551	4.147	1.539	0.910	2.297	0.872	0.777
55	4.684	1.779	1.053	2.543	0.969	0.611	4.649	1.768	1.046	2.508	0.972	0.870

For $10,000 Dependent Child Coverage, regular rate is $7.50 semiannual. At time of application, a quarterly or semiannual billing option can be selected. (Quarterly premiums will be one-half of the semiannual premiums. Note that rates shown above may not be exact due to rounding and depending on the billing option selected.)

Premiums are based on the applicant's age at date of issue and on attained age at renewal dates.

*The initial premium will not change for the first 10 or 20 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

The classes of rates are "Nontobacco Super-Preferred," "Nontobacco Preferred" and "Tobacco." Nontobacco users may qualify for the higher "Preferred" rates. (Note: Tobacco users may only qualify for the "Tobacco" rates.) Upon approval of your application, you will be notified of the rate classification for each approved person. You will be billed on a quarterly or semiannual basis.

Acceptance into this plan is subject to medical evidence of insurability as determined by ReliaStar Life. Depending on your age, amount of coverage you request and your answers on the application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience at no expense to you.

Note: If you choose the Accidental Death and Dismemberment (AD&D) option, you will receive the same level of coverage as your 10-Year or 20-Year Level Life Insurance up to $500,000. The AD&D rate is $6.00 (quarterly) or $12.00 (semiannually) per $50,000 of AD&D coverage, regardless of your age, gender and tobacco use status.

Product provisions and availability may vary by state.

Questions?

Call Toll-Free 1-800-775-2020 • 8:00 AM - 5:00 PM Monday-Friday

If you have any questions about your eligibility, what the plan covers, rates, or how to complete the application, please do not hesitate to call. A Client Advisor will be able to immediately provide you with the information you need. Or you can email us: COA.Insurance.service@getamba.com

KEEP THIS INFORMATION WITH YOUR IMPORTANT PAPERS. This package contains a brief description of the benefits available. Complete details can be found in Group Policy 66997-1. Underwritten by ReliaStar Life Insurance Company and administered by Association Member Benefits & Insurance Agency. Policy Form #LP08GP

CA Insurance License #0I96562 • Association Member Benefits & Insurance Agency

800-775-2020 • COA.Insurance.service@getamba.com • www.COAMemberInsurance.com

Sponsored by:

Underwritten by: ReliaStar Life Insurance Company
20 Washington Avenue South
Minneapolis, MN 55401-1900

The package contains a brief description of the benefits available. Complete details can be found in Group Policy 66997-1, Policy Form #LP08GP. This program may not be available to residents of all states.

The California Optometric Association receives sponsorship fees for insurance programs that offset the cost of program oversight and support member benefits and services.

Program Administered by:

Association Member Benefits & Insurance Agency
P.O. BOX 14555
Des Moines, IA 50306

Group Level Term Life Application
10-Year and 20-Year Level Term Rates

66997-1-0003

★ Return completed application to LH.Admin@getamba.com or mail to: AMBA, P.O. Box 14555, Des Moines, IA 50306

FOR MEMBERS AND SPOUSES OF THE CALIFORNIA OPTOMETRIC ASSOCIATION 3-657

1 TELL US ABOUT YOURSELF

MEMBER INFORMATION *(COMPLETE THIS SECTION ONLY IF APPLYING FOR MEMBER COVERAGE ON THIS APPLICATION)*

Name (Last, First, M.I.) ☐ Male ☐ Female

Date of Birth (MM/DD/YYYY) | Place of Birth | Social Security Number

Address | City | State | ZIP

Home/Cell Phone # | Work Phone # | Email Address

SPOUSE OF MEMBER INFORMATION *(COMPLETE THIS SECTION ONLY IF APPLYING FOR SPOUSE OF MEMBER COVERAGE ON THIS APPLICATION)*

Name (Last, First, M.I.) ☐ Male ☐ Female | Name of Member

Date of Birth (MM/DD/YYYY) | Place of Birth | Social Security Number

Address | City | State | ZIP

Home/Cell Phone # | Work Phone # | Email Address

DEPENDENT CHILD(REN) INFORMATION *(COMPLETE THIS SECTION ONLY IF APPLYING FOR DEPENDENT CHILD(REN) ON THIS APPLICATION)*

Number of eligible children | Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below.

Name | DOB | SSN

Name | DOB | SSN

Name | DOB | SSN

Name | DOB | SSN

Address | City | State | ZIP | Home/Cell Phone #

PLEASE COMPLETE AND SIGN ►

	Member	Spouse
a. Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
Date of last use (month/year)	_____ / _____	_____ / _____
b. Are you currently working less than 30 hours per week at your regular occupation and place of business?	☐ Yes ☐ No	☐ Yes ☐ No
c. Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please explain

2 SELECT YOUR COVERAGE

Member Amount

☐ **10-Year Level Term**
☐ **20-Year Level Term**

☐ $500,000
☐ $750,000
☐ $1,000,000
☐ Other: $_____ *in $50,000 increments*
(Minimum: $200,000; Maximum: $1,000,000)

Spouse of Member Amount

☐ **10-Year Level Term**
☐ **20-Year Level Term**

☐ $500,000
☐ $750,000
☐ $1,000,000
☐ Other: $_____ *in $50,000 increments*
(Minimum: $200,000; Maximum: $1,000,000)

Please select if you wish to include additional options with your coverage

☐ $10,000 Dependent Child(ren) Coverage*
☐ Member Accidental Death & Dismemberment
☐ Spouse Accidental Death & Dismemberment

** If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.*

3 PROVIDE YOUR HEALTH INFORMATION

Member: Height ____ ft. ____ in. Weight ____ lbs. Spouse of Member: Height ____ ft. ____ in. Weight ____ lbs.

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member

Spouse

	Member	Spouse
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	☐ Yes ☐ No	☐ Yes ☐ No
2) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack), sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?	☐ Yes ☐ No	☐ Yes ☐ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?	☐ Yes ☐ No	☐ Yes ☐ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?	☐ Yes ☐ No	☐ Yes ☐ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?	☐ Yes ☐ No	☐ Yes ☐ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?	☐ Yes ☐ No	☐ Yes ☐ No
3) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?	☐ Yes ☐ No	☐ Yes ☐ No
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
5) 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?	☐ Yes ☐ No	☐ Yes ☐ No
6) Have you, in the last five years, had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?	☐ Yes ☐ No	☐ Yes ☐ No

a. Member's driver's license number and state of issue

b. Spouse's driver's license number and state of issue

7) Have you ever applied for insurance that was declined, postponed or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
8) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?	☐ Yes ☐ No	☐ Yes ☐ No

PLEASE COMPLETE AND SIGN ►

For every "Yes" answer to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Q#	APPLICANT	DESCRIPTION OF CONDITION	DATE CONDITION BEGAN	DESCRIPTION OF TREATMENT RECEIVED	HEALTH PRACTITIONER NAME, FULL ADDRESS AND PHONE
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				

4 DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

BENEFICIARY FOR MEMBER COVERAGE *(COMPLETE THIS SECTION ONLY IF APPLYING FOR MEMBER COVERAGE ON THIS APPLICATION)*

Name (Last, First, M.I.)

Date of Birth (MM/DD/YYYY) | Social Security Number | Relationship | Percent

Address | City | State | ZIP | Home/Cell Phone #

Name (Last, First, M.I.)

Date of Birth (MM/DD/YYYY) | Social Security Number | Relationship | Percent

Address | City | State | ZIP | Home/Cell Phone #

BENEFICIARY FOR SPOUSE OF MEMBER COVERAGE *(COMPLETE THIS SECTION ONLY IF APPLYING FOR SPOUSE OF MEMBER COVERAGE ON THIS APPLICATION)*

Name (Last, First, M.I.)

Date of Birth (MM/DD/YYYY) | Social Security Number | Relationship | Percent

Address | City | State | ZIP | Home/Cell Phone #

Name (Last, First, M.I.)

Date of Birth (MM/DD/YYYY) | Social Security Number | Relationship | Percent

Address | City | State | ZIP | Home/Cell Phone #

PLEASE COMPLETE AND SIGN ►

5 COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

DIRECT BILL: ☐ Quarterly ☐ Semiannual

Billing dates will begin after coverage is approved and initial premium has been received.

6 READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have 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 in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life Insurance Company.

Authorization and Acknowledgment — Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, 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, pharmacy prescriptions or prescription records or any nonmedical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these 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, its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, 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. 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, 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.

Member's Signature X _____ **Date signed** X _____

Spouse's signature (if applying) X _____ **Date signed** X _____

Owner of Member Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.) _____ Date of Birth (MM/DD/YYYY) _____ Social Security Number _____

Address _____ City _____ State _____ ZIP _____ Home/Cell Phone # _____

Owner's Signature _____ Date _____

Owner of Spouse of Member Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.) _____ Date of Birth (MM/DD/YYYY) _____ Social Security Number _____

Address _____ City _____ State _____ ZIP _____ Home/Cell Phone # _____

Owner's Signature _____ Date _____

SEND NO MONEY NOW. SIMPLY MAIL THIS FORM TO:

Association Member Benefits & Insurance Agency
4050 NW 114th Street
Urbandale, IA 50322-9795

CA Insurance License #0I96562

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

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, LLC., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." 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, LLC, 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, LLC.

We or our reinsurers may make brief reports to MIB, LLC (hereafter "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. 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.