Life

ING TERM APPLICATION

ING

Your future. Made easier.SM

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the ING family of companies
Order #136903 **PA** 12/11/2006

DO

- Do print in dark ink.
- Do obtain all the necessary signatures.
- Do complete Agent's Report.
- Do have applicant initial all changes.
- Do present the Proposed Insured with the following forms:
  - Consumer Privacy Notice (If a copy will not been presented to Owner.)
  - Authorization for Release of Health Information (A completed copy must also be submitted with the application.)
  - Valuable Information About Your Term Life Insurance Purchase (If a copy will not been presented to Owner.)
- Do present the Owner with the following forms:
  - Consumer Privacy Notice (If a copy will not been presented to Proposed Insured.)
  - Conditional Receipt, when premium has been accepted and the form has been completed and signed. (One copy must be completed and submitted. The second copy is for the Owner's records.)
  - Valuable Information About Your Term Life Insurance Purchase (If a copy will not been presented to Proposed Insured.)
- Do have all checks made payable to ReliaStar Life Insurance Company.

DO NOT

- Do not use pencil or correction fluid.
- Do not attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- Do not promise or imply that we will provide insurance.
- Do not accept payment in the form of cash/currency or Traveler's checks.
- Do not accept a check or money order made payable to you or with the payee left blank.
- Do not accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.

MAILING OR FAXING INSTRUCTIONS

Mail or Fax all completed materials to the Administrative Office.

Mail to:
ING Service Center
P.O. Box 5052
Minot, ND 58702-5052

Fax to:
866-308-7743
Attn: ING Service Center

TERM APPLICATION

ReliaStar Life Insurance Company, Minneapolis, MN

A. PRODUCT INFORMATION

1. Initial Term Period: ☐ 10 Year ☐ 15 Year ☐ 20 Year ☐ 30 Year ☐ Other ______

2. Face Amount $ ______

3. Location of Sale *(city, state)* ______ Date ______

B. RIDER INFORMATION *Select only if available with product. Not all riders are approved in all states.*

☐ Waiver of Premium Rider

☐ Children's Insurance Rider *(Complete Children's Insurance Rider Application.)* $ ______

☐ Other______ $ ______

C. PROPOSED INSURED INFORMATION

1. First Name ______ MI ______ Last Name ______
2. Date of Birth ______ Birth State and Country ______
3. Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed
4. SSN/Government Issued ID# ______ Phone ______
5. Driver's License Number and State ______
6. Residence Address ______
   (P.O. Boxes are not permitted, other than APO/FPO) *City* *State* *ZIP*
7. Is the Proposed Insured a U.S. Citizen? *(If "No", complete the Foreign Travel and Residence Questionnaire.)*............☐ Yes ☐ No
8. Occupation *(include duties)* ______
9. Employer ______ Employer Phone ______
10. Employer Address ______
    City *State* *ZIP*
11. Proposed Insured's Annual Earned Income ______ Annual Interest & Other Income ______
12. Total Net Worth ______
13. Has the Proposed Insured ever used tobacco or nicotine products of any type? ....☐ Yes ☐ No
    If "Yes", indicate Type ______ Amount & Frequency ______ Month/Year Last Used ______

D. PROPOSED INSURED PERSONAL HISTORY

1. Has the Proposed Insured ever declared bankruptcy? *(If "Yes", provide details in chart below, including date discharged)*..........☐ Yes ☐ No
2. Is the Proposed Insured, or do they intend to become a member of the armed forces, including the Reserves or National Guard? *(If "Yes", complete Military Questionnaire.)*..........☐ Yes ☐ No
3. In the next 5 years, does the Proposed Insured intend to travel or reside outside the United States or Canada (other than a two week or less vacation to Western Europe or the Caribbean)? *(If "Yes", complete the Foreign Travel and Residence Questionnaire.)*..........☐ Yes ☐ No
4. Does the Proposed Insured anticipate flying a plane (other than as a commercial pilot), racing motor boats, automobiles or motorcycles, or participating in sky-diving, hang-gliding or other hazardous activities? *(If "Yes", complete the appropriate hazardous activities questionnaire.)*..........☐ Yes ☐ No

5. Except for traffic violations, has the Proposed Insured been the subject of or convicted in a criminal proceeding? *(If "Yes", provide details in chart below.)*........ ☐ Yes ☐ No
6. Has the Proposed Insured in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? *(If "Yes", provide details in chart below.)*........ ☐ Yes ☐ No

For any "Yes" answer to questions 1, 5 or 6, please record information in the chart below.

Ques. #	Explanation

E. BENEFICIARY INFORMATION

Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. *Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.*

Name (First, MI, Last)	DOB	Relationship	%	Beneficiary Type
				☐ Primary ☐ Contingent
				☐ Primary ☐ Contingent

If beneficiary is a Trust or Corporation, provide name and date of trust agreement and state of incorporation.

Name of Trust/Corporation__________ Date of Trust __________ State of Incorporation__________

F. OWNER *(PAYOR) Complete only if owner is to be other than Proposed Insured.*

1. Owner is: ☐ Individual ☐ Corporation ☐ Trust ☐ Sole Proprietorship ☐ Partnership ☐ Other __________
2. Full Name __________
3. Relation to Proposed Insured __________
4. Residence Address __________
   (P.O. Boxes are not permitted other than APO/FPO) City State ZIP
5. Billing Address __________
   City State ZIP
6. Phone __________ SSN/TIN or Government Issued ID#__________
7. Driver's License Number/State *(individual only)* __________ Date of Birth __________
8. Trust Contact Name __________ Date of Trust __________
9. Type of Trust: ☐ Revocable ☐ Irrevocable Purpose of the Trust __________
10. State of Incorporation __________ Name of Trustee/Corporate Officer__________
11. Does the above trustee have sole authority to act on behalf of the Trust? .... ☐ Yes ☐ No
    (If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees.)

G. REPLACEMENT INFORMATION *(Applies to both Owner and Proposed Insured.)*

If you intend to replace existing coverage, tell the Agent of your intention and answer "Yes" to the replacement questions (#2 and #3 below). State law may require the Agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Agent if you are unsure.

		Proposed Insured		Proposed Owner	
		Yes	No	Yes	No
1.	Do you have an existing or pending life insurance policy or annuity contract? *(If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)*	☐	☐	☐	☐
2.	Are you considering using funds from an existing policy or contract to pay premiums on the policy you are applying for? *(If "Yes", complete state required replacement form and provide details below.)*	☐	☐	☐	☐
3.	Are you considering replacing, discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*	☐	☐	☐	☐

Name	Insurance Company (Do not include group policies.)	Contract / Policy #	Account Value / Amount of Coverage	Date Issued

H. PAYMENT INFORMATION

1. Initial Payment: ☐ Check ☐ COD ☐ ~~Credit Card *(When available and selected, see #4 Credit Card Information.)*~~ N/A N/A N/A N/A
   ☐ Military Allotment *(Active or retired military members must complete Military Allotment form and return to the Military finance department.)*
   ☐ Civil Service Allotment *(Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit must be completed.)*

2. Initial Payment Amount $________________________________ Subsequent Payment Amount $____________________________

3. Frequency of Subsequent Payments:
   ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly *(Complete EFT form-Appendix E)*

4. ~~Credit Card Payment *(When available)*:~~ N/A N/A ☐ ~~Visa~~ N/A ☐ ~~MasterCard~~ N/A ☐ ~~Discover~~ N/A ☐ ~~American Express~~ N/A

   ~~Full Name *(Print as it appears on card)*~~ N/A N/A ____

   ~~Card Number~~ N/A N/A N/A ____________________ ~~Expiration Date~~ N/A N/A ____________

5. Would you like to backdate your policy to save age? *(If "Yes", see backdating disclosure, section M.)*.................. ☐ Yes ☐ No

I. MEDICAL TRANSFER STATEMENT *(Complete when submitting medical examinations from another insurance company.)*

1. Name of Insurance Company ______________________________________ 2. Date of Examination ____________________
3. To the best of your knowledge and belief, are the statements in the examination true and complete today?... ☐ Yes ☐ No
4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 2 above? *(If "Yes", please provide details below.)*... ☐ Yes ☐ No

____

J. REPLACEMENT VERIFICATION *(For Agent use ONLY)*

1. To the best of your knowledge and belief, will coverage under an existing life insurance policy or annuity contract be replaced, lapsed, surrendered, or borrowed against in relation to this application for insurance? *(If "Yes", submit state required replacement forms.)*.. ☐ Yes ☐ No
2. Is the Owner or the Proposed Insured considering using funds from an existing policy or contract to pay premiums on the policy being applied for? *(If "Yes", complete state required replacement forms and provide details below.)* .... ☐ Yes ☐ No
3. Has the Owner or the Proposed Insured discontinued making premium payments, surrendered, forfeited, assigned to the insurer, or otherwise terminated an existing policy or contract or are they considering doing so? *(If "Yes", complete state required replacement form and provide details below.)* .... ☐ Yes ☐ No

   Company ____ Policy # ____________________ Amount ____________________

K. IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to:

ING Service Center
Life New Business
P.O. Box 5052
Minot, ND, 58702-5052.

L. BACKDATING DISCLOSURE

As a policyholder, you may elect to backdate your policy, which enables you to gain benefits of a lower age for the purposes of calculating costs of insurance charges on your policy.

There are some inherent costs associated with your decision to backdate your policy. For each month that your policy is backdated the applicable costs of insurance charges are accumulated and deducted from your initial premium payment. If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

This page must be given to the Proposed Insured.

M. AUTHORIZATION AND ACKNOWLEDGEMENT

The undersigned Owner and Proposed Insured declare: By completing this life insurance application, I understand that I am applying for life insurance coverage issued by ReliaStar Life Insurance Company, referred to as the "Company." I understand and consent that this application and information obtained pursuant to this authorization may be used by the Company to evaluate my eligibility for life insurance. For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, clinic or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), any consumer reporting agency, or any other organization to release to the Company or their authorized representatives (including any consumer reporting agency) acting on their behalf, ALL INFORMATION requested by the Company about me and any minor children who are to be insured. This includes but is not limited to: Any medical information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and treatment of me or my minor children who are to be insured; Prescription drug records and related information maintained by physicians, pharmacy benefit managers and other sources; Any non-medical information about me or my minor children who are to be insured. By this authorization, each physician, medical practitioner, hospital, clinic or medically related facility contacted by the Company is instructed to provide the entire medical record in its possession concerning me or any minor children who are to be insured.

- I give my permission to the Company to collect consumer or investigative consumer reports about these same persons.
- I give my permission to the Company and other insurance companies affiliated with the Company to collect any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. I may revoke this permission and authorization as it applies to any information protected by 42CFR Part 2 or by applicable state law at any time by mailing the written revocation to the Company at the address on the Consumer Privacy Notice, but not to the extent action has been taken. I understand that the release of medical records will not be requested with respect to tests performed to determine the presence of the Human Immunodeficiency Virus (HIV) antibody.

For any life insurance application or other insurance transaction that I may have with the Company, I specifically consent that some or all of the information obtained by this authorization may be sent to MIB, reinsurers, the agent who solicited my application and his or her principals, employees or contractors who process transactions regarding any insurance coverage I may have applied for or have with the Company or affiliated companies. I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy.

- **I understand that I may request to be interviewed if an investigative consumer report is prepared. You may contact me between the hours of _____ am/pm and _____ am/pm. My daytime phone number is (_______)______________.**
- **I know that I have a right to receive a copy of this form and a photocopy will be as valid as the original.**
- **This form will be valid for 24 months from the date shown below.**
- **I acknowledge receipt of the following notices: Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.**

VERIFICATION:

Each of the undersigned also declares that:

A. I have read the statements and answers given in this application and affirm that they are true and complete to the best of my knowledge and belief. I understand that the Company may seek to rescind or cancel the insurance coverage if there is any material misrepresentation.

B. This application consists of Part I, appendices and supplemental questionnaires, and will be the basis for any coverage issued on this application. Any coverage issued on this application will take effect only upon satisfaction of all of the Company's requirements, except as otherwise provided in the Conditional Receipt, if issued, with the same date as this application. Except where permitted expressly by statute or regulation, no agent or medical examiner has the authority to waive the answer to any question in the application, to pass on insurability, to make or alter any contract or waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, plan of insurance or benefits on this application shall be effective unless agreed to in writing by the Proposed Insured and Owner.

C. I certify, under penalty of perjury, that my Social Security/tax identification number(s) is(are) shown and is(are) correct and that I am not subject to back-up withholding.

All completed materials must be sent to the Administrative Office at: ING Service Center, P.O. Box 5052, Minot, ND 58702-5052 or faxed to 866-308-7743.

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.

X Signature of Proposed Insured *(if age 18 or older)* ______________________________

Signed at: *(city/state)* ______________________________ Date ______________

X Signature of Owner *(if other than the Proposed Insured)* ______________________ Date ______________

Print Owner/Trustee Name ______________________________

X Signature of Parent or Guardian *(if the Proposed Insured is a minor)* ______________________________

X Signature of Writing Agent ______________________________

Print Writing Agent Name ______________________________

Writing Agent State Lic. # ______________________ Writing Agent # ______________________

Name of Agent ______________________________

Agent State Lic. # ______________________ Agent # ______________________

Life

AGENT'S REPORT

To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.

Agent Name (Please Print.)	Agent ID #	% Split	General Agent #	General Agent Name

Each licensed agent will share equally unless otherwise indicated.

A. COMPLIANCE INFORMATION

1. Have you delivered the Consumer Privacy Notice to the Proposed Insured(s) or Proposed Owner? ☐ Yes ☐ No
2. Did you meet personally with the applicant/owner and review their SSN/Government issued ID? *(If "No", explain below.)* ☐ Yes ☐ No
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Owner? ☐ Yes ☐ No
4. Will there be a rebate of any kind, such as a rebate of premium, to the Owner? ☐ Yes ☐ No
5. To your knowledge, does the Owner intend to change ownership of the policy after its issuance *(i.e. to a trust, viatical or life settlement company or other person)*? ☐ Yes ☐ No
6. Will any portion of the premiums for this policy be financed? ☐ Yes ☐ No
7. All sales materials have been approved by the Insurer, and the following were used in my sales presentation: ______________________________
8. Copies of all sales materials were left with the applicant no later than the time of application. *(Electronically presented sales materials will be provided to the policyowner no later than at the time of the policy delivery.)* Our Company requires that all replacement sales are made in accordance with the Company's corporate policy. If this particular sale is NOT in accordance with the Company's corporate replacement policy, please check here ☐ and attach an explanation.

B. PROPOSED INSURED/OWNER INFORMATION

1. How long have you known the Proposed Insured? ______________________________
2. Are you related? ☐ Yes ☐ No How? ______________________________
3. How much insurance does the Proposed Insured's spouse own payable to the Proposed Insured or other dependents? $______
4. If this application is for a juvenile, please indicate the amount of life insurance in force on each parent or sibling.
   Father $ ______________ Mother $ ______________ Sibling $ ______________
5. Please check the Underwriting requirements ordered: ☐ Blood Profile/HOS ☐ Inspection Report ☐ MD Exam ☐ Treadmill EKG ☐ EKG ☐ Paramedical Exam Paramed Company ______________

C. REMARKS

Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.

D. ACKNOWLEDGEMENT

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent or Producer Agreement ("Agreement"), whichever is applicable, including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker/Dealer and do not hold an Agreement such that this language is inapplicable.

I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

E. AGENT SIGNATURE

Agent Signature(s) ______________________________ Date ______________

Contact for Requirements ______________________________ Agent SSN ______________

Agent Phone ______________ Fax ______________ Email Address ______________

CONDITIONAL RECEIPT

ReliaStar Life Insurance Company, Minneapolis, MN

IF WITHIN THE LAST YEAR, THE PROPOSED INSURED HAS RECEIVED ANY TREATMENT OR ADVICE FROM A PHYSICIAN FOR TUMOR OR CANCER OR ANY BRAIN, HEART, LUNG OR KIDNEY DISORDER, A CONDITIONAL RECEIPT MAY NOT BE GIVEN AND PREMIUM MAY NOT BE COLLECTED.

Premium received from ______________________________ in the amount of $ ____________ in payment of the first full modal premium for an insurance policy applied for on the life of ____

____

Proposed Insured, for whom this application as dated below has been made to ReliaStar Life Insurance Company.

This Conditional Receipt does not create temporary or interim insurance and it does not provide any coverage except as provided herein. If any of the below questions are answered YES or LEFT BLANK, the agent is not authorized to accept a premium, and there will be NO COVERAGE. Premium may be paid by check, authorized withdrawal or credit card payment. Make all checks payable to the Company, not the agent.

I. REPRESENTATIONS — Applicable to the Proposed Insured named above.

1. Has the Proposed Insured:
   a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which the Proposed Insured has not consulted a physician? ☐ Yes ☐ No
   b. ever had, or now have, any type of heart disease, stroke, or other vascular disease? ☐ Yes ☐ No
   c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the immune system? ☐ Yes ☐ No
   d. attained age 70? ☐ Yes ☐ No
2. For the Proposed Insured, is the initial amount of life insurance applied for on all applications pending with the Company plus the current amount of all existing life insurance with the Company more than $1,000,000? ☐ Yes ☐ No
3. For the Proposed Insured, does existing life insurance with all insurers plus amount applied for in pending application(s) with all insurers exceed $10,000,000? *(For #2 and #3 amount of insurance calculations, include all policies, term riders, and accidental death coverage and second to die coverage for the Proposed Insured.)* ☐ Yes ☐ No

II. TERMS AND CONDITIONS OF COVERAGE UNDER THIS RECEIPT

Amount of Coverage: If the Proposed Insured dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders if issued as applied for under the Application; or (b) $1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or conditional receipts on the life of Proposed Insured, the Company's total liability shall not exceed $1,000,000; and the $1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured.

General: Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. All the above representations are true and complete to the best of my knowledge and belief. I agree that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

Coverage begins when premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Owner's address shown on the application; or
- Five days after a notice of termination is mailed to the Owner's address shown on the application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

There is no insurance coverage if:

- There is material misrepresentation in the answers to the questions above or to any question or statement in the Application.
- The Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
- The premium check, authorized withdrawal or credit card payment is not honored.

Owner Signature ______________________________ Date __________ Signed at *(city/state)* ______________

Proposed Insured Signature ______________________________ Date __________ Signed at *(city/state)* ______________

Licensed Agent Signature ____ Date ________________

Agent Name *(please print)* ________________________ Agent Phone ______________________________

1st Copy to Administrative Office **2nd Copy to Owner**

CONDITIONAL RECEIPT

ReliaStar Life Insurance Company, Minneapolis, MN

IF WITHIN THE LAST YEAR, THE PROPOSED INSURED HAS RECEIVED ANY TREATMENT OR ADVICE FROM A PHYSICIAN FOR TUMOR OR CANCER OR ANY BRAIN, HEART, LUNG OR KIDNEY DISORDER, A CONDITIONAL RECEIPT MAY NOT BE GIVEN AND PREMIUM MAY NOT BE COLLECTED.

Premium received from ______________________________ in the amount of $ ____________ in payment of the first full modal premium for an insurance policy applied for on the life of ____

____

Proposed Insured, for whom this application as dated below has been made to ReliaStar Life Insurance Company.

This Conditional Receipt does not create temporary or interim insurance and it does not provide any coverage except as provided herein. If any of the below questions are answered YES or LEFT BLANK, the agent is not authorized to accept a premium, and there will be NO COVERAGE. Premium may be paid by check, authorized withdrawal or credit card payment. Make all checks payable to the Company, not the agent.

I. REPRESENTATIONS — Applicable to the Proposed Insured named above.

1. Has the Proposed Insured:
   a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which the Proposed Insured has not consulted a physician? ☐ Yes ☐ No
   b. ever had, or now have, any type of heart disease, stroke, or other vascular disease? ☐ Yes ☐ No
   c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the immune system? ☐ Yes ☐ No
   d. attained age 70? ☐ Yes ☐ No
2. For the Proposed Insured, is the initial amount of life insurance applied for on all applications pending with the Company plus the current amount of all existing life insurance with the Company more than $1,000,000? ☐ Yes ☐ No
3. For the Proposed Insured, does existing life insurance with all insurers plus amount applied for in pending application(s) with all insurers exceed $10,000,000? *(For #2 and #3 amount of insurance calculations, include all policies, term riders, and accidental death coverage and second to die coverage for the Proposed Insured.)* ☐ Yes ☐ No

II. TERMS AND CONDITIONS OF COVERAGE UNDER THIS RECEIPT

Amount of Coverage: If the Proposed Insured dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders if issued as applied for under the Application; or (b) $1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or conditional receipts on the life of Proposed Insured, the Company's total liability shall not exceed $1,000,000; and the $1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured.

General: Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. All the above representations are true and complete to the best of my knowledge and belief. I agree that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

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Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Owner's address shown on the application; or
- Five days after a notice of termination is mailed to the Owner's address shown on the application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

There is no insurance coverage if:

- There is material misrepresentation in the answers to the questions above or to any question or statement in the Application.
- The Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
- The premium check, authorized withdrawal or credit card payment is not honored.

Owner Signature ______________________ Date __________ Signed at *(city/state)* __________

Proposed Insured Signature ______________________ Date __________ Signed at *(city/state)* __________

Licensed Agent Signature ______________________________ Date __________

Agent Name *(please print)* ______________________ Agent Phone ______________________

1st Copy to Administrative Office **2nd Copy to Owner**

Life

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

ReliaStar Life Insurance Company, Minneapolis, MN
Administrative Office: ING Service Center, P.O. Box 5052, Minot, ND 58702-5052

This authorization complies with the HIPAA Privacy Rule.

Name of Proposed Insured/Patient (please print) ______________________________ Date of Birth ____________

Address of Proposed Insured/Patient ____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to "the Company" and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that "the Company" may: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with "the Company".

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to "the Company", Attention: Privacy Official, ING Service Center, P.O. Box 5052, Minot, ND, 58702-5052. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that "the Company" has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, "the Company" may not be able to process my Application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative ______________________________ Date ________

Description of Personal Representative's Authority or Relationship to Patient *(please print)* ______________________

A copy of this Authorization must be given to the Proposed Insured.

CONSUMER PRIVACY NOTICE

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. 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. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. 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, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. 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 ReliaStar Life Insurance Company (the "Company"). You may request that this information not be communicated to other companies affiliated with the Company.

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; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

Notice Regarding MIB (Medical Information Bureau, Inc.)

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is 866-692-6901 and fax is 866-346-3642.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Notice Regarding Information Practices

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

This page must be given to the Proposed Insured and/or Owner.

VALUABLE INFORMATION ABOUT YOUR TERM LIFE INSURANCE PURCHASE

ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO

Thank you for considering ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company") for your life insurance needs. We offer various life insurance products that have different features, benefits and costs. Your professional insurance agent may work with many life insurance companies, and we are pleased that your agent has presented one of our products to you.

We'd like you to understand how we pay the selling agent. Agents earn a commission for each Company policy sold. The commission is generally a percentage of the policy premiums you pay. The percentage may be higher for agents that sell a larger number of Company policies. Agents may receive additional compensation for each year a policy remains in force or for achieving certain sales volume levels. The actual percentage and amount of compensation paid will vary based on the specific circumstances of your purchase.

Agents may receive additional non-cash compensation from us as a reward for things like achieving sales contest objectives or other measures. We also may pay for agent education, training or attendance at conventions, and may provide financing, or other payments or benefits. In addition, some agents may be associated with independent marketing organizations ("IMOs") that have agreements with us. IMOs provide administrative services to independent agents and marketing support for our policies. The Company may make payments to IMOs that may be based on the amount of premium written with the Company by agents associated with the IMO.

This is a general discussion of the compensation we pay for the sale of our policies. We pay commissions and other sales expenses from our general assets and revenues, including amounts we earn from fees and charges under our policies. The price of an insurance policy is set by the Company and reflects the compensation we pay for the sale of the policies. It also covers costs we incur for the design, manufacture and service of our policies, for policy benefits and features including guarantees, and for the investment management needed to support the policies' values. We are committed to providing top-quality insurance products to our customers and are pleased that your professional insurance agent trusts us to deliver on your long-term insurance needs.

This notice must be given to the Proposed Insured/Owner.

Life

CREDIT CARD PAYMENT AUTHORIZATION AND ELECTRONIC FUNDS TRANSFER

ReliaStar Life Insurance Company, Minneapolis, MN
ING Service Center, P.O. Box 5052, Minot, ND 58702-5052

A. CREDIT CARD PAYMENT AUTHORIZATION

This service is not available in Alaska, California, Maryland, New Jersey, New York and North Carolina.

Request and Authorization for Credit Card Payment of Initial Premium: ReliaStar Life Insurance Company (the "Company") is hereby requested and authorized to initiate a credit card transaction to be charged against the account described in the Authorization below for the ***initial payment only***. Subsequent premium payments will be made either by direct billing or monthly EFT.

Insured Name (Please print.)	Policy #	Payment Amount

Credit Card Type: ☐ MasterCard ☐ Visa ☐ Discover

Full Name *(Print as it appears on card.)* ______________________

Account # |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Expiration Date *(month and year)* ______________

I authorize ReliaStar Insurance Company to charge my initial insurance premium for the policy numbers listed above, to the credit card account I have indicated. I understand that this payment will be for the initial premium only, and that I will either be billed for subsequent payments directly or by EFT if I have indicated so on previous pages of this application.

Signature of Cardholder[1] ______________________

B. ELECTRONIC FUNDS TRANSFER

Request and Authorization Agreement for Pre-Arranged Payments or Electronic Bank Debit Plan for Payment of Premiums: ReliaStar Life Insurance Company (the "Company") is hereby requested and authorized to draw checks or initiate bank debits to be charged against the Account described in the Authorization below. **Important Notice for Term Insurance Premiums:** Premiums paid more frequently than annually result in higher total premiums for the same coverage.

This agreement authorizes: ☐ A new monthly transfer ☐ A change in existing transfer amount ☐ A change in financial institution

Insured Name (Please print.)	Policy #	Monthly Deduction

Bank Name ______________________

Bank Address ______________________

Account type: ☐ Checking ☐ Savings Name(s) on Account ______________________

Routing # |_|_|_|_|_|_|_|_|_| Account # ______________________

[1]Payment cannot be processed without signature.

B. ELECTRONIC FUNDS TRANSFER *(Continued)*

Tape voided check here. Forms submitted without a voided check will not be accepted. Deposit slips will only be accepted in lieu of voided checks for Savings Accounts.

Terms of the EFT Plan Each debit will be: (1) in an amount sufficient to pay a proper proportion of the annual premium at the Company's EFT premium rate; (2) notice of premium due and no further notice of premium will be given; (3) a receipt for the amount stated thereon if and when the Company receives actual payment. If a debit is not honored by the bank upon presentation for payment by the Company, such action by the bank will be notice of nonpayment of premium. The EFT Plan for premium payment may be terminated by the Policyowner or by the Bank Depositor/premium payor by written notice filed with the Company and may be terminated by the bank in which the Account is maintained. The Company also may terminate without notice if any debit is not honored upon presentation, otherwise upon 30 days written notice to the Policyowner. In the event the Plan is terminated for any cause, any unpaid premiums, and premiums which have due dates that occur on or after the date of termination, will be paid directly to the Company at the premium rate and on the premium due date which would have been applicable to each policy if it had not been placed under the EFT Plan for premium payment. If the Company is not paid within the time required by the policies, the said policies will lapse and have no further value, except as otherwise provided in said policies. The Company may, at its discretion from time to time, effect payments by use of prearranged payments (debit) or an electronic bank debit system. **It is agreed that:** This authorization will apply to any conversion, renewal or change made in said policies; the Company encourages the Policyowner to obtain overdraft protection from its bank to avoid any unhonored withdrawals and associated fees; the Company may increase the premium withdrawal amount sufficient to maintain insurance coverage. Such increase would occur 30 days after providing written notification of the increase. **Authorization Agreement for Prearranged Payments (debits)** I (we) authorize the Company to make variable charges to my (our) checking or savings Account identified above, and authorize the financial institution named above to withdraw funds from (debit) such Account and pay to the Company's order accordingly. This authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me (us) to terminate this agreement. I have read and understand the above statement:

Signature of Account Owner ______________________________ Date ____________________

SSN/TIN ______________________________ Phone ____________________

☐ ReliaStar Life Insurance Company
Home Office: Minneapolis, MN
Administrative Office:
P.O. Box 5075
Minot, ND 58702-5075

☐ Security Life of Denver Insurance Company
Home Office: Denver, CO
Administrative Office:
P.O. Box 5065
Minot, ND 58702-5065

ACKNOWLEDGEMENT IN LIEU OF ILLUSTRATION SUBMISSION - PENNSYLVANIA

For use when no illustration is used during solicitation, when the policy applied for is different than as shown in the illustration used during solicitation or when a computer screen was used during solicitation.

Definition of Illustration: An illustration is any written or computer information that depicts the non-guaranteed values of a life insurance policy over a period of time greater than one year. For example, a document that shows non-guaranteed values as of age 65 would be an illustration.

I. **Applicant**: I acknowledge that: (please select one)

- ☐ No illustration was used in this solicitation
- ☐ The illustration(s) used in this solicitation did not conform to the policy applied for
- ☐ A computer screen was used in this solicitation and the information described below was displayed.

INFORMATION DISPLAYED ON COMPUTER SCREEN

Name of insured: ______________________ Name of insured: ______________________

Age: __________ Gender: __________ Underwriting Classification: ______________________

Generic name of policy: ______________________

Company product name: ______________________ Form #: ______________________

Generic name of rider(s): ______________________

Guaranteed interest rate: ______________________ Non-guaranteed interest rate: ______________________

Number of policy years illustrated: ______________________ Initial death benefit: ______________________

Premium amount illustrated is $__________ which is payable __________ (mode) for __________ (assumed number of years premiums will be paid)

Name of insurer: ______________________

Name and address of agent: ______________________

I understand that if a computer screen illustration was presented to me during solicitation that a written illustration matching that shown on the computer screen will be provided to me prior to submission of the application. I also understand that an illustration matching any policy issued to me will be provided to me with the policy.

Applicant signature ______________________ Date ______________________

Applicant signature ______________________ Date ______________________

II. **Agent**: I certify that:(please select one)

- ☐ No illustration was used in the solicitation of this application for insurance.
- ☐ The illustration(s) used in this solicitation did not conform to the policy applied for.
- ☐ A computer screen was displayed in this solicitation and that the information described above was displayed.

I have explained that any non-guaranteed elements of the policy are subject to change. I have made statements on non-guaranteed elements that are wholly consistent with the illustration that will be provided to the applicant at policy delivery.

Agent signature ______________________ Date ______________________

Agent number ______________________

☐ ReliaStar Life Insurance Company
☐ Security Life of Denver Insurance Company

ING Service Center
2000 21st Avenue, NW
Minot, ND 58703

Consent to Blood (and Other Body Fluids) Testing
Disclosure Authorization

I give my consent to the above named insurer, its employees, contractors, affiliated companies and reinsurers, to conduct the following:

(1) Blood (and/or other body fluids) test for antibodies to the AIDS virus (HIV); if I reside in a state which permits insurers to conduct this test; and

(2) Such other or additional tests which the company may lawfully order.

My consent to this testing is freely given, based on the following understandings:

(1) The purpose of the test(s) is to determine whether I am insurable for life insurance.

(2) I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood (and/or other body fluids) tested and by refusing to give sample(s). I know that if I do not take the test(s), my application to the company for life insurance will be declined.

(3) The test(s) for the antibodies to the AIDS virus (HIV) will be conducted following approved test protocols.

(4) If state law permits, I will be notified of positive HIV test results. Otherwise, I will be asked to designate, in writing, the name and address of the physician to whom I want the test results sent. I understand that in some states positive results may only be disclosed to the physician I designate to receive the results.

I further understand that test results will not be released or disclosed to any party (other than the company and related parties identified above, to whom I hereby authorize disclosure) unless:

(a) I expressly authorize their release in writing; or
(b) A public health reporting law requires disclosure; or
(c) A court order requires disclosure.

I understand that disclosures under 4(b) and 4(c) may be made without my consent.

(5) I understand that the company may report to the Medical Information Bureau (MIB) any abnormal blood (and/or other body fluids) test, but the company will not disclose the type of blood (and/or other body fluids) test which was abnormal. I acknowledge receipt of the company's Notice Regarding the MIB, Inc.

I know that I have the right to get a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO TESTING AND DISCLOSURE AUTHORIZATION.

Name of Proposed Insured	Signature of Proposed Insured
State of Residence of Proposed Insured	Date
Name of Examiner	Signature of Examiner

ReliaStar Life Insurance Company
Home Office: Minneapolis, MN
Administrative Office:
P.O. Box 5075
Minot, ND 58702-5075

LIVING BENEFIT RIDER
DISCLOSURE STATEMENT

The accelerated benefit rider, better known as ReliaStar's Living Benefit Rider, allows the owner to access a portion of the life insurance death benefit if the insured becomes terminally ill (life expectancy of 6 months or less as determined by a physician). The benefit is always payable to the owner.

There is no additional premium required to issue this rider. If you request an accelerated benefit, an interest charge and an administrative expense charge will be deducted from the amount you request.

When an accelerated benefit is paid, the death benefit, cash values and loan values of the policy will be reduced proportionally. The amount will be determined at the time you request a Living Benefit payment.

For example, suppose you purchase a policy with a $100,000 death benefit. Later, you request a Living Benefit payment of $25,000. Any charges noted above would be deducted from the $25,000 and the resulting total would be your Living Benefit payment. The death benefit on your policy would then be reduced to $75,000, and any required premium would be reduced proportionally. If your policy has cash values, those accumulations would also be reduced proportionally.

Limitations of the Accelerated Benefit:

(a) The rider is not intended to replace health or disability coverage. Rather, it provides an added source of funds to meet critical needs during a difficult time. You choose how the funds will best meet your needs. There are no restrictions on how a Living Benefit payment can be used.

(b) Accelerated benefits payable under this rider may or may not be taxable. You should consult your personal tax advisor.

(c) Receipt of accelerated benefits under this product may affect medicaid and supplemental security income ("SSI") eligibility.

If at some future point in time, you decide that you no longer wish to carry the Living Benefit Rider on your coverage, you may request that it be removed. The Living Benefit Rider will automatically terminate when the life insurance policy matures.

The Living Benefit Rider is subject to eligibility requirements.

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization is HIPAA compliant.

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(please print)* ______________________________

Date of Birth ______________________ SSN/ITIN ______________________

Proposed Insured/Patient Address ______________________________

AUTHORIZATION INFORMATION

This will authorize:

______________________________ (*Physician, Clinic or Hospital Name)*

to release medical information to ______________________________ *(the Life Insurance Agent/Agency).*

Authorized Life Insurance Carrier(s) ______________________________

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, according to the terms of this authorization. This includes any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Insurance Agent/Agency named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Insurance Agent/Agency may provide the information to the listed carrier(s) so that they may: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Insurance Agent/Agency.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Insurance Agent/Agency named above at the following address.

Attention: Privacy Official

Agency Address ______________________________

City ______________ State ________ ZIP __________

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Proposed Insured/Patient or
Personal Representative Signature ______________________________ Date ______________

Description of Personal Representative's
Authority or Relationship to Patient *(please print)* ______________________________

A copy of this authorization must be given to the Proposed Insured.

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES - PENNSYLVANIA

ING

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ Security Life of Denver Insurance Company, Denver, CO

Administrative Office:
ING Service Center
2000 21st Ave. NW
Minot, ND 58703
877-882-5050

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read this notice carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing insurance you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misstatement or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, will grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have twenty (20) days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us. You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

Signature of Applicant ______________________________ Date ______________

Signature of Agent ______________________________ Date ______________

1st Copy: Applicant 2nd Copy: Insurer 3rd Copy: Producer

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured ______________________ Age ________________ Sex ________________

*Name of Agent preparing disclosure ____

*Agent home or agency address ____

*Telephone number of Agent ____

Name of Insurer ____

Home Office Address of Insurer (City & State) ____

Direct all correspondence to (Insurer's home, executive or administrative office) ______________________

	Descriptive Title of Coverage	Face Amount of Coverage (1)	Annual Premium (2)
*Policy	If not shown here, description detailed on second page)	***	(If a Flexible Premium Adjustable Whole Life policy is chosen, see (3) below)
*Rider(s)			
*Supplemental Benefit(s) (built into policy)			The cost is included in the premium for the policy.

(1) The face amount of coverage of the (policy, rider, supplemental benefits) changes as follows ______________________

____

(2) The premium for the (policy, rider) changes; the ultimate (annual, monthly, etc.) premium will be ______________ at ______________ policy year (age) [or representative (annual, monthly, etc) premiums will be ______________ and ______________ and ______________, and the ultimate (annual, monthly, etc.) premium will be ______________ at ______________ and ______________ and ______________ policy years (ages) respectively] [or the premium will (increase ______________% each year) and the ultimate (annual, monthly, etc.) premium will be ______________ at ______________ policy year (age).]

(3) For a Flexible Premium Adjustable Whole Life policy, the planned periodic premium for the specified face amount and mode shown above is $ ______________. The amount and mode of the planned periodic premium can be changed at any time. In addition, unscheduled premium payments of at least $500 may be made according to the terms of the contract. Any unscheduled premiums will be treated like planned periodic premiums in the determination of cash values.

Total (Initial) (annual, monthly, etc.) premium for the policy and rider will be ______________.

*Retirement Income. Your policy is designed to pay a guaranteed retirement income of $ ______________ starting at (age, year) for (life), but not for less than 10 years.

*Guaranteed Cash Value. If you pay all your premiums on this policy as they come due, you will have the guaranteed cash values shown on the following page.

*You may borrow against this cash value at an annual ______________ % loan interest charge.

*If inapplicable to insurance being offered section may be deleted entirely or clearly marked "Not Applicable."

*** The amount shown is the initial face amount if a Flexible Premium Adjustable Whole Life policy is chosen.

1st Copy: Applicant 2nd Copy: Insurer 3rd Copy: Producer

Number of Years Policy had been In Force	5	10	20	Age 65
Total Accumulated Cash Value per $1000 (or Total Face Amount)				

On ____________________, if your policy is a Flexible Premium Adjustable Whole Life policy, your policy and its riders will cease to be in effect based on the planned periodic premiums being paid, interest being credited at the guaranteed interest rate, and the maximum cost of insurance rates being charged.

Interest in excess of the guaranteed rate, and cost of insurance rates less than the maximum, may be credited or charged. Either of these actions will produce cash values greater than those shown above.

*Dividends. The following is a dividend illustration for your policy based on the current interest, mortality and expense experience of the company or fraternal benefit society as reflected in the dividends currently paid. However, the illustrations are not a guarantee of what future dividends will be. Payment of a dividend is contingent upon the payment of the next premium due.

Number of Years Policy had been In Force	10	20
Illustrated Dividend for that Individual Year per $1000 (or Face Amount)		

*A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

*The prospective insured has ____________________ has not ____________________ requested an earlier delivery of the index.

Upon request either the company, fraternal benefit society or agent will furnish you with additional information about the insurance described.

Flexible Premium Adjustable Life Insurance

This Flexible Premium Adjustable Whole Life Insurance contract provides life insurance as long as premiums paid and interest credited are more than charges for mortality and expenses. The amount of life insurance coverage is adjustable and can be increased or decreased at the option of the policyholder. Any increase in coverage is subject to evidence of insurability. Cash values are accumulated from the payment of the flexible premiums which can be paid at anytime and in varying amounts. Each month interest is credited to the cash value. Also each month, certain expense charges and the cost of the preceding month's insurance protection are deducted from the cash value.