Group Term Life Application

Please complete the entire application. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to* ***Insurance Specialists Inc, P.O. Box 2327, Beaufort, SC 29901.***

1 Tell us about yourself

Name of Association

ISI Insurance Trust	Group Policy No:

You are applying as: ☐ Association Member ☐ Spouse of Member

Your Name *(last, first, middle)*		☐ Female ☐ Male	Name of Member
Date of Birth	Height	Weight	Social Security Number
Address			
City	State	ZIP	
Home Phone	Work Phone	Email Address	

Owner (if other than yourself.) *The owner controls all rights to the certificate.*

Name	Address	
City	State	ZIP

- If you are a ***new*** applicant, indicate ***initial*** amount of coverage applied for: $____________ in $5,000 increments
- If you are ***increasing*** coverage, indicate amount of ***additional*** coverage applied for with this application: $____________ in $5,000 increments
- Check box(es) to purchase:
  - ☐ $__________ Accidental Death & Dismemberment
  - ☐ $__________ Dependent Child Insurance
- Are you currently working at least 30 hours per week at your regular occupation and place of business? ☐ Yes ☐ No
- Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? ☐ Yes ☐ No

  If yes, please explain: ________________________________

2 Beneficiary information

List one or more beneficiaries below. List the percent each will receive. The total must equal 100 percent. *Beneficiary for dependent coverage will be the certificate holder.*

Name	Address	Relationship	Percent

ReliaStar Life Insurance Company • Box 20 • Minneapolis, MN 55440

Please complete and sign back of application.

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Provide us with this health information

a.) Have you, for any condition during the past 12 months, consulted a physician/health practitioner, received surgical or medical care, or taken prescribed medication? ☐ Yes ☐ No

b.) Have you ever been treated or diagnosed by a physican for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV? ☐ Yes ☐ No

c.) Have you ever been diagnosed with or been treated for: disease or disorder of heart; lungs; nervous/mental system (including anxiety and depression); liver; kidneys; stomach; colon or genito-urinary system; stroke; high blood pressure; cancer or tumor; diabetes; or arthritis? ☐ Yes ☐ No

d.) Have you ever sought help or received counseling or treatment for alcohol or drug use, or are you currently using illegal drugs? ☐ Yes ☐ No

e.) Have you ever applied for insurance that was declined, postponed or modified in any way? ☐ Yes ☐ No

If you answered "yes" to any of the questions above, please give full details below.
Attach additional sheets if needed.

Q#	Name	Conditions/illness/treatment	Date(s) of treatment	Physician/health practitioner's name and complete mailing address

f.) List the name and address of your regular physician/health practitioner and the date you last consulted him or her:

____

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Read this information carefully, then sign and date below

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

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

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, 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. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

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

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

Your Signature	Date Signed
Signature of Owner *(if other than yourself)*	Date Signed