ISI ALABAMA
a division of
INSURANCE SPECIALISTS, INC.
EST. 1959

ISI Direct: 1-888-ISI-1959
Fax: 843-525-9992

ALABAMA STATE BAR

Affinity Yearly Renewable Term Life Application • Standard Issue

Members and their spouses can apply for this coverage. Each applicant should complete a separate application.

Applicant Information

Name of Association Alabama State Bar			Are you applying as: ❑Association Member ❑Spouse of a Member		
Name *(Last, First, Middle Initial)*	Date of Birth *(mm/dd/yy)*	Height *(ft., in)*	Weight *(lbs)*	Sex	
Social Security Number	Home Phone Number	Work Phone Number			
Address *(Street, City, State / Province, Zip Code)*					

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

Name	Address *(Street, City, State / Province, Zip Code)*

- If you are a new applicant, indicate initial amount of coverage *(in $10,000 increments)*: $______
- If you are increasing coverage, indicate amount of additional coverage applied for with this application *(in $10,000 increments)*: $______
- Optional coverages: ❑Accidental Death Benefit ❑Disability Waiver of Premium ❑Children's Insurance Rider: $10,000 on each child
- Have you used tobacco products of any kind in the last 12 months? ❑Yes ❑No
- Will this proposed insurance replace any of your current life insurance or annuities? ❑Yes ❑No

  If yes, please explain: ______

- Are you currently working at least 30 hours per week at your regular occupation and place of business? ❑Yes ❑No

Beneficiary Information

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

Name	Address	Relationship	Percent
Name	Address	Relationship	Percent

Health Information

	Yes	No
a. Have you, for any condition during the past 12 months, consulted a physician, received surgical or medical care, or taken prescribed medication?	❑	❑
b. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus?	❑	❑

Please complete and sign the back of application.

	Yes	No
c. Have you ever had or been treated for nervous, brain or lung disorders, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury, or other disease or disorder?	❑	❑
d. Have you ever sought help or received counseling or treatment for anxiety/depression, alcohol or drug use, or are you currently using illegal drugs?	❑	❑
e. Have you ever applied for insurance that was declined, postponed or modified in any way?	❑	❑

f. *If you answered "yes" to any of the questions above, please give details below and on additional sheets if needed.*

Nature of illness, injury, or operation	Date(s) of treatment	Residual Health Problems	Name and address of doctors and hospitals

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

Name	Address	Date of you last consulted him or her

If you are applying for SUPER-PREFERRED RATES, please fill out questions h, i, j and k.	Yes	No
h. Has your mother, father, or any sister or brother died prior to age 70 as a result of heart disorder, stroke, or cancer?	❑	❑
i. Have you in the last 3 years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?	❑	❑
j. Have you used tobacco or nicotine in any form in the last 5 years?	❑	❑
k. Have you in the last 3 years had any motor vehicle accidents, DUI convictions (driving under the influence) or other moving violations?	❑	❑

Please provide your driver's license number:______________________________

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 and the first premium is paid during my lifetime.
- I understand coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment *Please read and sign below.*

For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons. I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates. I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 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, files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

Your Signature	Date

Owner Signature *(if other than yourself)*	Date

ADMINISTRATOR USE ONLY	Group Number	Ass'n Name		Signature of Licensed Ins. Rep.
HOME OFFICE USE ONLY	Premium Received with Application		Effective Date	Signature of Licensed Ins. Rep.

 Super-Preferred Application ❑Yes ❑No