

Request for Insurance and Payroll Deduction RELIASTAR LIFE INSURANCE COMPANY (RELIASTAR) THE NGAUS TECHNICIAN PROTECTION PROGRAM

Agreement

I request participation in the insurance plan offered by ReliaStar. I understand that, upon issuance, I will become a Member of the NGAUS Insurance Trust. I understand that my employer, as a service performed for me, will make regular payroll deductions for the premiums.

The information I have given on this application is furnished to obtain the insurance and is true and complete to the best of my knowledge and belief. I direct that all experience credits declared as a result of my participation in the NGAUS Insurance Trust, after payment of Trust expenses, shall be paid to the National Guard Association of the United States or The National Guard Educational Foundation, as determined by the NGAUS Insurance Trust. No obligation shall be incurred because of information furnished unless and until coverage is approved by ReliaStar and the first premium is paid in full.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We may make brief reports to 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 on 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 files. If you ask, MIB will arrange for disclosure of the information it has about you in its file. However, only the licensed physician you choose will be given medical information. If you feel the information in MIB's file is not correct, you may contact MIB and ask them to correct it as provided in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. 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 benefits may be submitted.

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.

THIS APPLICATION IS NOT APPLICABLE TO RESIDENTS OF SOUTH CAROLINA,
SOUTH DAKOTA, TEXAS, OHIO AND OREGON

1. Please complete the information requested. Please print in ballpoint pen. Press firmly

Applicant's name (First, Middle Initial, Last)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth month / day / year	Age	Social security number	
Address		City	State	Zip	Height ' "	Weight lbs.
Applicant's daytime phone number ()		Location of pay office	Pay office phone number ()		Pay office code	
Employing office		Date of employment month / day / year	Job duty		Annual Salary	

2. Fill out this section if you are applying for spouse coverage.

Spouse's name (First, Middle Initial, Last)		Date of Birth month / day / year	Height ' "	Weight lbs.	Social security number
Employer		Occupation			

3. Select the coverage you want. New Application Change/add coverage

A. Term Life Insurance

Amount Coverage

Technician \$25,000 \$50,000 \$150,000 \$250,000 Other Amount: _____

Spouse \$25,000 \$50,000 \$150,000 \$250,000 Other Amount: _____

Child(ren) per child \$5,000 \$10,000

B. Disability Income (Technician)

Salary Under \$18,000 \$18,000 to \$27,999 \$28,000 to \$31,999 \$32,000 to \$39,999 \$40,000 to \$49,999 \$50,000 and over

C. Supplemental Disability Income (Technician) (must have Basic Disability)

Salary Under \$20,000 \$20,000 to \$23,999 \$24,000 to \$25,999 \$26,000 to \$31,999 \$32,000 to \$39,999 \$40,000 to \$49,999 50,000 and over

Note: Coverages A, B & C do not require completion of the health questions if the Applicant applies for \$25,000 or \$50,000 within 31 days of the date of employment. (All Spouse coverage requires evidence of insurability)

FOR OFFICE USE ONLY - Deduction amount for above coverages

A. _____ B. _____ C. _____			1st payroll deduction
Deduction amount	Effective date month / day / year	Transmittal number HRO	Consec. no.

4. Complete if you want children's coverage.

List the names and birthdates of all unmarried dependent children, stepchildren, and legally adopted children age 14 days to age 19 (to age 25 if a full time student at an accredited educational institution).

First	Middle	Last	Date of birth month / day / year
First	Middle	Last	Date of birth month / day / year
First	Middle	Last	Date of birth month / day / year

5. Name of Beneficiary for each life plan applied for. (Name and Relationship)

- Term Life (Technician) _____
- Term Life (Spouse) _____

Beneficiary of the Children's Coverage will be the insured parent.

6. Health Questions

(NOTE: The Technician, if applying for Group Term Life, Disability Income or Supplemental Disability Income, within 31 days of employment does not have to complete this section. If applying for these coverages after 31 days of employment or applying for Supplemental Term (coverage over \$50,000), Technician must answer these health questions.

Spouse must always answer the health questions when applying for coverage.

In Minnesota, the applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. **Refer to the Authorization and Acknowledgement section for a definition of "Emergency Medical Personnel".**

- | | | |
|---|--|--|
| | Technician | Spouse |
| A. Have you had medical attention, consulted a physician or been hospitalized in the last 5 years? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. At the present time are you under a doctor's care or taking medication for any condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. In the last five years have you been diagnosed or treated by a physician for any of the following?
Circle each specific condition: Lung disorder, high blood pressure, heart trouble, nervous disorder, ulcer, liver or stomach disorder, kidney or urinary disorder, diabetes, arthritis, back trouble, cancer, eye or ear impairment, any female disorder, or any physical defect or deformity? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For each "Yes" answer, give details below: *(If necessary, please attach additional sheet signed and date by Technician and Spouse if applying).*

Nature of illness, injury or treatment	Person to whom it applies	Date of treatment	Physician's name and address

7. Please Read and Sign

Authorization and Acknowledgement

For underwriting purposes, I give my permission to:

Any physician, or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar) ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, or surgery as they apply to me or my spouse who are to be insured.

LIMITATIONS, if any:

I understand all or part of this information may be sent to MIB, Inc. It may also be made available to any ReliaStar reinsurer, employee, or contractor who processes transactions that concern any insurance I may have applied for or have with ReliaStar.

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

In Minnesota, this authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "**emergency medical personnel**" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squads personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota Security Hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

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 a 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 26 months from the date shown below or for 2 years from the date the policy is issued, whichever is earlier.

I acknowledge that I have read the notice regarding MIB on the front side of this application.

X	X	X	X
_____ Technician's Signature (if applying)	_____ Today's Date (Mo./Day/Yr.)	_____ Spouse's Signature (if applying)	_____ Today's Date (Mo./Day/Yr.)

WHITE – Original-ReliaStar

CANARY – Payroll Office

PINK – HRO

GOLD – Retain For Your Records

NGAUS-APPMN

E-Ship: 125435 (10/04)