ReliaStar Life Insurance Company
Security Life of Denver Insurance Company
Members of the ING family of companies

Individual Term Life Insurance Application

Term Products

ING

Agent's Checklist:

- ☐ Underwriting Company, Product, Product Type, Base Coverage, and Death Benefit questions have been completed.
- ☐ Supplemental Rider options have been selected. Refer to the product specs for specific information on rider availability.
- ☐ Required personal information for the Proposed Insured has been completed.
- ☐ Required information for Primary and Contingent Beneficiaries has been completed.
- ☐ Questions regarding existing life insurance have been completed and detailed properly. If any question is marked "Yes", complete all required replacement forms.
- ☐ Personal History Information have been completed and detailed thoroughly, where applicable.
- ☐ The "Signed At" and "Date" fields have been completed along with appropriate signatures under the Authorization and Acknowledgement section.
- ☐ The Agent's Report has been completed and submitted with the application.
- ☐ When applicable, the Electronic Funds Transfer form has been completed.
- ☐ An Authorization for Release of Health-Related Information has been submitted for the Proposed Insured with the application.
- ☐ Appendices A, C and D have been given to the Proposed Insured.
- ☐ A copy of this application has been provided to the Owner and/or Proposed Insured.
- ☐ Applicable state required notices were provided at time of application. Refer to the Forms Wizard tool on the ING for Professionals website, via www.inglifeinsurance.com, for the forms required by state.

Reminders:

- Do not use pencil or correction fluid.
- Do not 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 MONEY OR ISSUE THE TEMPORARY INSURANCE RECEIPT if any representation in the Temporary Insurance Receipt (Appendix A) is answered **"Yes"** or **left blank**.
- 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 has attained age 70.
- This application cannot be used for the ING HomeGuard Plus or ING HomeGuard Plus Select products.

THIS APPLICATION MAY NOT BE USED IF THE POLICY TO BE PURCHASED IS OR MAY BE USED FOR THE BENEFIT OF A THIRD PARTY (A "STRANGER") THAT LACKS AN INSURABLE INTEREST IN THE INSURED. A PERSON GENERALLY HAS AN INSURABLE INTEREST IN THE LIFE OF AN INSURED WHERE THE PERSON HAS A CONTINUED INTEREST IN THE SURVIVAL OF THE INSURED. THE COMPANY OPPOSES STRANGER-OWNED/STRANGER-ORIGINATED LIFE INSURANCE TRANSACTIONS ("STOLI") AND WILL SEEK TO TERMINATE ANY SUCH INSURANCE COVERAGE WHILE RETAINING PREMIUMS PAID, COSTS AND/OR DAMAGES. MATERIAL MISREPRESENTATION REGARDING THE FACTS PRESENTED TO THE COMPANY FOR UNDERWRITING THE APPLICATION OR ATTEMPTS TO DEFRAUD THE COMPANY MAY RESULT IN ADDITIONAL LEGAL ACTION. PLEASE SEE SECTION A AND SECTION Q OF THE APPLICATION.

Mail or fax all completed materials to the ING Customer Service Center

Mail to: ING Customer Service Center, PO Box 5075, Minot, ND 58702-5075

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

Get confirmation from your General Agent to send applications directly to us.

RESET FORM

Life

INDIVIDUAL TERM LIFE INSURANCE APPLICATION

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
("the Company")

This application may not be used if the policy to be purchased is or may be used for the benefit of a third party (a "stranger") that lacks an insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company opposes stranger-owned/stranger originated life insurance transactions ("STOLI") and will seek to terminate any such insurance coverage while retaining premiums paid, costs and/or damages. Material misrepresentation regarding the facts presented to the Company for underwriting the application or attempts to defraud the Company may result in additional legal action. Please see Section Q of the application.

A. PRODUCT INFORMATION *(This application is for use with term products only.)*

1. Product Requested _____ 2. Face Amount $ _____

3. Initial Term Period: ☐ 10 Year *(not available with all products)* ☐ 15 Year ☐ 20 Year ☐ 30 Year ☐ Other _____

B. RIDER INFORMATION *(Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

☐ Accidental Death Benefit Rider . . . . . $ _____
☐ Children's Insurance Rider
(Complete Children's Insurance Rider Application.)
☐ Waiver of Premium Rider
☐ Other _____
☐ Other _____

C. PROPOSED INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____
2. Birth Date _____ Birth State/Country _____ Gender: ☐ Male ☐ Female
3. E-mail _____ SSN or Government Issued ID Number _____
4. Daytime Phone (_____)_____ Evening Phone (_____)_____ Best Time to Call _____
5. Residence Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
6. Are you a U.S. Citizen? *(If "No", complete the Foreign Travel and Residence Questionnaire.)*. . . . . ☐ Yes ☐ No
7. Occupation/Duties _____
8. Employer _____ Employer Phone (_____)_____
9. Employer Address _____
10. Do you currently or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . . . ☐ Yes ☐ No
    If "Yes", indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____
11. Driver's License Number _____ 12. Driver's License State _____
    (If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
13. Name on Driver's License *(if different than above)* _____

D. OWNER *(If Proposed Owner is a Trust or Corporation, provide first and last pages of the Trust document, including signatures. The Trust must be established prior to the application date.)*

1. Full Name of Owner/Trust/Corporation *(30 character limit)* _____
2. Owner Relationship to Proposed Primary Insured _____
3. Owner Birth Date _____ Owner Phone (_____)_____ Owner SSN/TIN _____
4. Owner Address *(PO Boxes are not permitted.)* _____
5. Corporation Contact Name _____
6. Address of Trust/Corporation _____
7. Billing Address _____

D. OWNER *(Continued)*

8. Type of Government Issued ID *(Driver's License/Passport)* _____ Document Number _____

Issuing State or Country _____ Issuance Date _____ Expiration Date _____

9. Trust Contact Name _____ TIN _____ Trust Date _____

10. Purpose of the Trust _____ Type of Trust: ☐ Revocable ☐ Irrevocable

11. State of Incorporation _____ Trustee/Corporate Officer Name _____

12. 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 on the application.)

E. PAYOR *(Complete only if the payor is to be other than the owner.)*

1. Payor Name _____

2. Payor Address *(PO Boxes are not permitted.)* _____

F. 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.)*

1. Is the Beneficiary a Trust? . . . . . ☐ Yes ☐ No

2. Trust/Corporation Name _____ Trust Date _____ State of Incorporation_____

Name (First, MI, Last)	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent

G. PROPOSED INSURED PERSONAL HISTORY

1. Are you, or do you intend to become a member of the armed forces, including the Reserves, or on alert? *(If "Yes", complete Military Questionnaire.)* . . . . . ☐ Yes ☐ No
2. Do you intend to travel or reside outside the United States or Canada in the next two years? *(If "Yes", complete Foreign Travel and Residence Questionnaire.)*. . . . . ☐ Yes ☐ No
3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? *(If "Yes", complete Aviation Questionnaire.)*. . . . . ☐ Yes ☐ No
4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? *(If "Yes", complete Avocations and Professional Sports Questionnaire.)* . . . . . ☐ Yes ☐ No
5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes or dune buggies? *(If "Yes", complete Motor Sports Questionnaire.)*. . . . . ☐ Yes ☐ No
6. Except for traffic violations, have you been convicted in a criminal proceeding or are you the subject of a pending criminal proceeding? ☐ Yes ☐ No
7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? . . . . . ☐ Yes ☐ No

For any "Yes" answer to questions 6-7, please record information in the chart below.

Question	Explanation

H. PAYMENT INFORMATION

1. Initial Payment Amount[1] $ _____ Initial Payment: ☐ Check ☐ Cash on Delivery ☐ Credit Card ☐ EFT

2. Subsequent Payment Amount $_____ Subsequent Payments Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly[2]

☐ Military Allotment[3] *(Active or retired military members must complete the Military Allotment form and return it to the military finance department.)*

☐ Civil Service Allotment *(The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)*

[1] *To draft the initial premium payment, complete Appendix E.*
[2] *To draft monthly payments, complete Section B of Appendix E.*
[3] *Two monthly premium payments are required before the policy becomes active.*

I. AUTOMATIC PREMIUM LOAN (APL) *(Available with Endowment Benefit Products only.)*

If you elect the APL Option, you direct the Company to pay premiums due but not paid by the end of the grace period by taking a loan against any available Loan Value. If the available Loan Value is not sufficient to pay the premium then due, the policy may terminate.

☐ I elect the Automatic Premium Loan (APL) Option

J. FUNDED ERISA INFORMATION *(Complete if the policy will be owned by a "Funded ERISA Plan".)*

Is the insurance for a tax-qualified, pension, profit sharing or defined contribution ERISA plan, or a VEBA or welfare benefit arrangement? . . . ☐ Yes ☐ No

Plan Provider Name _____

☐ Tax-qualified plan *(specify profit sharing, defined benefit, or defined contribution)* _____

☐ Section 419/419A(f)(6) welfare benefit or VEBA plan ☐ Other *(specify type and name of plan)* _____

K. LIST BILL INFORMATION - EMPLOYER-SPONSORED PLANS ONLY *(For a new List Bill plan, please contact the List Bill Department at 877-886-5050.)*

1. Is the insurance employer-sponsored? ☐ Yes ☐ No List Bill/File Code Number *(if plan already exists)* _____

2. Employer Plan Name *(if plan already exists)* _____ 3. Phone (_____)_____

4. Address _____

L. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? ☐ Yes *(If "Yes", review the policy backdating notice below.)*

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

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.

I understand, on backdated policies, that the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

M. FINANCIAL DETAILS

1. Is the applied-for policy in accordance with your insurance objectives and your anticipated financial needs? . . . . . ☐ Yes ☐ No
2. Do you believe you have the financial ability to continue making premium payments on this policy? . . . . . ☐ Yes ☐ No
3. Have you or your company ever declared bankruptcy? *(If "Yes", provide details including date discharged.)* . . . . . ☐ Yes ☐ No

_____

4. **Personal Insurance** *(For Personal Insurance complete questions 4-6; for Business Insurance complete questions 7-10.)*
☐ Estate Liquidity ☐ Family Protection ☐ Tax Planning ☐ Retirement Planning ☐ Cash Accumulation
☐ Other _____

5. Annual Earned Income $ _____ Annual Interest and Other Income $ _____

6. Total Assets $ _____ Total Liabilities $ _____ Total Net Worth $ _____

7. **Business Insurance**: ☐ Buy/Sell ☐ Key Person ☐ Other _____

8. Total Business Assets $ _____ Total Business Liabilities $ _____ Total Business Net Worth $ _____

9. Business Net Profit After Taxes for Past Two Years: Last Year $ _____ Previous Year $ _____

M. FINANCIAL DETAILS *(Continued)*

10. Business Owner Name	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?
		$	%	☐ Yes ☐ No
		$	%	☐ Yes ☐ No

N. IN FORCE/REPLACEMENT INFORMATION *(Applies to both Owner and Proposed Insured. If a replacement is occuring, the owner is required to terminate the existing policy with a separate written request to the insurance provider.)*

	Proposed Insured		Proposed Owner	
	Yes	No	Yes	No
1. Do you currently have life insurance inforce or applied for? *(If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)*	☐	☐	☐	☐

Insured Name	Insurance Company *(Do not include group policies.)*	Policy Number	Amount	Date Issued
			$	
			$	
			$	
			$	

	Proposed Insured		Proposed Owner	
	Yes	No	Yes	No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*	☐	☐	☐	☐
3. Are you considering 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.)*	☐	☐	☐	☐

4. For any "Yes" answer to questions 2-3, provide details regarding the policies being replaced in the chart below.

Insured Name	Insurance Company	Policy Number	Amount
			$
			$
			$
			$

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

1. Insurance Company Name _____ 2. Examination Date _____

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

_____

_____

P. REPLACEMENT VERIFICATION *(For Agent use ONLY. If a replacement is occurring, the owner is required to terminate the existing policy with a separate written request to the insurance provider.)*

1. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? *(If "Yes", submit state required replacement forms.)* . . . . . ☐ Yes ☐ No
   a. Is the applicant considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating their existing policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*. . . ☐ Yes ☐ No
   b. Is the applicant considering using funds from their existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes", complete state required replacement form.)* . . . . . ☐ Yes ☐ No

Company _____ Policy Number _____ Amount $ _____

Q. ING'S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI)

The Company, along with other ING Life Companies strongly opposes arrangements designed to obtain life insurance for the benefit of a third party (a "stranger") that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. We believe this position supports the best interests of our policy owners, as stranger-owned or stranger-originated life insurance transactions ("STOLI") will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business. The Company will seek to terminate the insurance coverage under any contract determined to be STOLI or where material misrepresentation has occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

The Company does not sell life insurance in the following circumstance:

- If, at the time of sale or conversion, the applicant/owner has an intent, plan, arrangement or understanding with a third party that will result directly or indirectly in the sale, assignment, settlement or other transfer to an investor, such as a life settlement company, or any other party with no insurable interest in the life of the insured who purchases the policy for investment purposes;
- If, at the time of sale or conversion, the applicant/owner has an intent, plan or arrangement to transfer an ownership interest or beneficial interest in an entity that will own the policy to a life settlement company or any other party with no insurable interest in the life of the insured;
- If, in connection with the sale, the applicant/owner and/or the insured is offered any compensation, reward or benefit, or other inducement to purchase or assist in the purchase the policy, including, but not limited to, cash payments, property such as a life insurance death benefit for "free" or at "no cost" or any other benefit of any kind;
- Where a sales concept, design, marketing plan, marketing material or other program that has not been disclosed to the Company is used in connection with the sale (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending arrangement where the lender's sole collateral for the premium loan is limited to the values of the policy itself);
- Where the producer and/or applicant knows, or has reason to know, that the source of funds for premium payments under a policy has not been disclosed to the Company (including, but not limited to, any arrangement to pay for premiums under the policy through a loan through a premium financing arrangement or other third party funding) ; or
- In any other circumstance determined by the Company, in its sole discretion, to be inconsistent with our policies on STOLI, insurable interest or misrepresentation.

The activities described above are considered "prohibited conduct".

R. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION

Representations and acknowledgements: By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and represent that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. Unless otherwise stated in a Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, and the first premium is received by the Company while the Proposed Insured is alive. If I have paid premium with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

R. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION *(Continued)*

By my signature below, I affirmatively warrant and represent that I have not engaged in any prohibited conduct described in Section Q above in connection with this application for insurance.

Authorization and Statements of Understanding: I authorize the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original.

I acknowledge receipt of the following disclosures and notices: Accelerated Benefit Rider and Critical Illness Disclosures, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. I certify, under penalty of perjury, that my Social Security Number/tax identification number is shown and is correct and that I am not subject to back-up withholding.

If an investigative consumer report is prepared, I request to be interviewed. ☐ Yes

Daytime phone number: (_____)_____.

Contact me between the hours of ___ a.m./p.m. and ___ a.m./p.m.

By my signature below I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:

Governing Law. The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

Jurisdiction. Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

All completed materials must be sent to the ING Customer Service Center at: 2000 21st Ave. NW, Minot, ND 58703

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

Proposed Owner Signed at *(city/state)* _____ Date _____

Proposed Owner Signature *(if other than the Insured)* _____

Proposed Owner/Trustee Name *(please print)* _____

Proposed Insured Signature _____ Date _____
(if other than the owner & age 15 or older)

Parent or Guardian Signature _____ Date _____
(if the Proposed Insured is a minor)

By signing below I acknowledge that I have not engaged in prohibited conduct as described in Section Q, "ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI)," nor am I aware of such conduct by the applicant

Writing Agent Signature _____ Date _____

Writing Agent Name *(please print)* _____

Writing Agent State Lic. Number _____ Writing Agent Number _____

TEMPORARY INSURANCE RECEIPT

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 1290 Broadway, Denver, CO 80203
("the Company")

ING
Your future. Made easier.®

I. PREMIUM RECEIPT *(On the lives of the Proposed Primary Insured and Proposed Other Insured named below)*

Amount Received $ _____ Date _____ Policy Application Date _____

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS *(For each Proposed Insured named below)*

1. Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
   a. any type of heart disease, stroke or other vascular disease? . . . . . ☐ Yes ☐ No
   b. any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system? . . . . . ☐ Yes ☐ No
2. In the past five years has any Proposed Insured experienced:
   a. unintentional weight loss? . . . . . ☐ Yes ☐ No
   b. any symptom(s) for which he/she has not yet consulted a health Care Provider? . . . . . ☐ Yes ☐ No
3. Has any Proposed Insured attained age 70? . . . . . ☐ Yes ☐ No

III. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) 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 covering the life or lives of the Proposed Insured(s) 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 temporary insurance receipts on the lives of Proposed Insured(s), 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(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. 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. Premiums are billed from the policy date. If the policy date is prior to the issue date, premiums are due based on the policy date.

Coverage begins when Part I of the Application is completed, a 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 Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed 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.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.
There is no temporary insurance receipt coverage if:

- **Any of the above representations is answered YES or LEFT BLANK.**
- **If Section 1035 exchange paperwork is received without premium payment.**
- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name *(please print)* _____ Signed at *(city/state)* _____

Proposed Owner Signature _____ Date _____

Proposed Insured Name *(please print)* _____ Signed at *(city/state)* _____

Proposed Insured Signature
(if other than the Proposed Owner) _____ Date _____

Proposed Other Insured Name *(please print)* _____ Signed at *(city/state)* _____

Proposed Other Insured Signature _____ Date _____

Writing Agent Name *(please print)* _____ Agent Phone (_____)_____

Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE CENTER 2ND COPY TO PROPOSED INSURED

Life

TEMPORARY INSURANCE RECEIPT

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 1290 Broadway, Denver, CO 80203
("the Company")

ING
Your future. Made easier.®

I. PREMIUM RECEIPT *(On the lives of the Proposed Primary Insured and Proposed Other Insured named below)*

Amount Received $ _____ Date _____ Policy Application Date _____

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS *(For each Proposed Insured named below)*

1. Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
   a. any type of heart disease, stroke or other vascular disease? . . . . . ☐ Yes ☐ No
   b. any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system? . . . . . ☐ Yes ☐ No
2. In the past five years has any Proposed Insured experienced:
   a. unintentional weight loss? . . . . . ☐ Yes ☐ No
   b. any symptom(s) for which he/she has not yet consulted a health Care Provider? . . . . . ☐ Yes ☐ No
3. Has any Proposed Insured attained age 70? . . . . . ☐ Yes ☐ No

III. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) 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 covering the life or lives of the Proposed Insured(s) 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 temporary insurance receipts on the lives of Proposed Insured(s), 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(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. 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. Premiums are billed from the policy date. If the policy date is prior to the issue date, premiums are due based on the policy date.

Coverage begins when Part I of the Application is completed, a 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 Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed 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.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.
There is no temporary insurance receipt coverage if:

- **Any of the above representations is answered YES or LEFT BLANK.**
- **If Section 1035 exchange paperwork is received without premium payment.**
- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name *(please print)* _____ Signed at *(city/state)* _____

Proposed Owner Signature _____ Date _____

Proposed Insured Name *(please print)* _____ Signed at *(city/state)* _____

Proposed Insured Signature
(if other than the Proposed Owner) _____ Date _____

Proposed Other Insured Name *(please print)* _____ Signed at *(city/state)* _____

Proposed Other Insured Signature _____ Date _____

Writing Agent Name *(please print)* _____ Agent Phone (_____)_____

Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE CENTER 2ND COPY TO PROPOSED INSURED

AGENT'S REPORT

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

Agent Name/Broker-Dealer *(please print)*	Agent ID Number	% Split	General Agent Number	General Agent Name

A. COMPLIANCE INFORMATION

1. Did you meet personally with the Proposed Owner and review their government issued ID? *(If "No", explain in Section D.)* . . . . . ☐ Yes ☐ No
2. Did you obtain the Proposed Insured's Medical Declarations in person and record them in the presence of the Proposed Insured? *(If "No", explain in Section D and arrange for an exam.)* . . . . . ☐ Yes ☐ No
3. Was an initial premium payment accepted? . . . . . ☐ Yes ☐ No
   If "Yes", was the Temporary Insurance Receipt completed and delivered to the Proposed Insured or Proposed Owner? . . . . . ☐ Yes ☐ No
4. Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? . . . . . ☐ Yes ☐ No
5. Has the Proposed Owner or Proposed Insured previously sold or assigned a policy to a life settlement or viatical company? . . . . ☐ Yes ☐ No
   If "Yes", provide details. _____
6. Will financing *(using any source other than the client's assets)* of premium payments be used now or is it contemplated within the next two years? . ☐ Yes ☐ No
   a. If "Yes", complete the Financing Disclosure & Acknowledgment.
   b. If "No", what is the source of funds used to pay premiums on this policy? (Check all that apply below.)

	Initial	Future
Current income	☐	☐
CDs or savings	☐	☐
Mutual funds or brokerage account	☐	☐
Existing life insurance policy(ies) or annuity contract(s)	☐	☐
Other	☐ _____	☐ _____

B. PROPOSED INSURED/OWNER INFORMATION

1. How long have you known the Proposed Insured? _____ 2. Are you related? ☐ Yes ☐ No How? _____
3. How much life insurance is in force on the Proposed Insured's spouse/domestic partner, payable to the Proposed Insured or other dependents? $_____
4. What is the annual income of the Proposed Insured's spouse or domestic partner? $_____
5. If this application is for a juvenile, indicate the amount of life insurance in force on each parent or sibling.
   Father $ _____ Mother $ _____ Sibling $ _____
6. If underwriting requirements were ordered, which paramedical vendor was used? _____

C. RELATED APPLICATIONS *(List all applications that are concurrently being submitted to ING for the Insured's family members and/or business partners.)*

Proposed Insured Names and Amounts applied for _____

D. REMARKS *(Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.)*

E. ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent Producer or other agent agreement ("Agreement"), 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.

I certify that all sales materials used during this sale were approved by the Company. 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 policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Company's corporate policy. I acknowledge that I have delivered the Important Notices (Consumer Privacy Notice & MIB) to the Proposed Insured(s) or Proposed Owner. I affirm that the answers above are complete and true to the best of my knowledge and belief.

Agent Signature(s) _____ Date _____

Contact for Requirements _____ Agent SSN *(Optional - Last 4 digits only)* _____

Agent Phone _____ Fax _____ E-mail _____

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization is HIPAA compliant.

PROPOSED INSURED INFORMATION

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

Birth Date _____ SSN/TIN _____

Proposed Insured/Patient Address _____

City _____ State _____ ZIP _____

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 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 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 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 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/PROPOSED OTHER INSURED.

IMPORTANT NOTICES

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, the Company ("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 or 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 the Company unless you request otherwise.

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, Inc.
(Medical Information Bureau)

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 (MIB), Inc. MIB is a nonprofit 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 mailing address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. The phone number is 866-692-6901 and the fax number is 866-346-3642. The MIB website address is www.mib.com.

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.

Federal Regulations - 42CFR Part 2

Your medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. If information is protected by federal or state law, you may revoke this authorization at any time by mailing a written request to the Company. A written request, however, will not apply to any information collected before the date that we receive your request.

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. When you apply for life insurance, we will ask for your name, address, birth date, 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 Customer Service Center
Life New Business
PO Box 5053
Minot, ND, 58702-5053

This page must be given to the Proposed Insured.

VALUABLE INFORMATION ABOUT YOUR TERM LIFE INSURANCE PURCHASE

Thank you for considering the Company for your life insurance needs. Your professional insurance producer may work with many life insurance companies, and we are pleased that your producer has presented one of our products to you.

We'd like you to understand how we pay the selling producer. Producers earn a commission for each policy sold. The commission is generally a percentage of the policy premiums you pay. The percentage may be higher for producers that sell a larger number of policies. Producers 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.

Producers 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 producer education, training or attendance at conventions, and may provide financing, or other payments or benefits. In addition, some producers may be associated with independent marketing organizations ("IMOs") that have agreements with us. IMOs provide administrative services to independent producers and marketing support for our policies. We may make payments to IMOs that may be based on the amount of premium written with us by producers 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. We set the price of an insurance policy and it 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 and our affiliates offer other insurance products in addition to the product you have selected. These other products may have different features, benefits, fees and charges and may provide you coverage that could meet your needs at a greater or lesser cost to you. We are committed to providing top-quality insurance products to our customers and are pleased that your professional insurance producer trusts us to deliver on your long-term insurance needs.

ACKNOWLEDGEMENTS

Notice Regarding Collection of Information and Information Practices

In order to evaluate your application for life insurance, we must collect information about you and any minor children who are to be insured. The type of information that we may collect includes, but is not limited to, the following: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information about you or your minor children who are to be insured. Some of that information will come from you. Some will come from other sources.

The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically related facilities, insurance or reinsuring companies, Medical Information Bureau ("MIB"), Inc., any consumer reporting agencies, and any other organizations. 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.

Proposed Insured/Owner: ***By signing Section R on the Individual Term Life Insurance Application, the Proposed Insured acknowledges receipt of these notices.***

Producer: ***By signing Section R on the Individual Term Life Insurance Application, the producers acknowledge that a copy of these notices have been provided.***

This page must be given to the Proposed Insured.

CREDIT / DEBIT CARD PAYMENT AUTHORIZATION AND ELECTRONIC FUNDS TRANSFER

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 1290 Broadway, Denver, CO 80203
("the Company")
A member of the ING family of companies
ING Customer Service Center, 2000 21st Ave. NW, Minot, ND 58703

ING
Your future. Made easier.®

The first premium payment will be applied when all policy requirements have been received. A specific draft date for subsequent premium payments can be requested, however, it may cause multiple drafts within the first 30 days.

A. CREDIT/DEBIT CARD PAYMENT AUTHORIZATION *(This is available for all Term Products except in Maryland, New York and North Carolina.)*

Request and Authorization for Credit/Debit Card Payment of Initial Premium: The Company is hereby requested and authorized to initiate a credit/debit 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 EFT.

Insured Name *(please print)*	Policy Number	Payment Amount
		$
		$
		$
		$

Premium Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

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

Account Number *(16 digits)* _____ Expiration Date *(month and year)* _____

Billing Zip Code _____ Credit/Debit Card Type: ☐ MasterCard ☐ Visa ☐ Discover

I authorize the Company to charge my initial insurance premium for the policy numbers listed above, to the credit/debit 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.

Cardholder Signature[1] _____

[1]*Payment cannot be processed without signature.*

B. ELECTRONIC FUNDS TRANSFER

What is the EFT plan?

The EFT plan allows us to pay your policy premiums by automatically withdrawing funds from your financial institution's account.

What happens if my financial institution does not honor a withdrawal?

If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. Premium payments are necessary to fund your policy; therefore, you will be required to send us a replacement payment. If we do not receive a replacement payment within the time required by your policy, your policy will enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage. To help prevent this, we encourage you to obtain overdraft protection from your bank.

How much will be deducted from my account?

We will only deduct premium payments according to the payment schedule outlined in your policy.

How can I cancel the EFT plan?

You have two options. You can write to us as the address above. Once we receive your request, we will cancel the plan within 7 – 10 business days. You may also call us at 877-886-5050 to cancel the plan.

We may cancel the plan without notice if a withdrawal is not honored or 30 days after we provide written notice to you.

If the plan is cancelled, you must pay any unpaid and future premiums directly to us on the premium due date. Termination of the plan does not change the premium due dates.

I'd like to enroll. Where do I sign?

Please read the following agreement and sign and date this form.

Authorization Agreement for Prearranged Payments

I authorize the Company to withdraw funds from my checking or savings account, identified on the next page, to pay premiums on my life insurance policy. This authorization will remain in effect until the Company has received a written request or phone call from me to terminate this agreement.

B. ELECTRONIC FUNDS TRANSFER *(Continued)*

Please Note: Premiums paid more frequently than annually may result in higher total premiums for the same coverage, depending on the product specifications.

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

Payment Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually *(Frequency other then monthly depends on the policy type.)*

Insured Name *(please print)*	Policy Number	Deduction
		$
		$
		$
		$

Request Specific Draft Date for Recurring Payments[2] *(Between the 1st and the 28th)* _____

Bank Name _____ Account Type: ☐ Checking ☐ Savings

Bank Address _____

City _____ State _____ ZIP _____

Name(s) on Account _____

[2] *Depending on the type of policy you own, the draft date options may vary. Please call us at 877-882-5050 option 1, option 1 for more information.*

For checking accounts, please tape a voided check in the space below. If you cannot provide this, you may write the bank routing number and account number in the appropriate fields.

Tape voided check here.

Routing Number *(9 digits)* _____ Account Number _____

Account Owner Signature _____ Date _____

SSN/TIN _____ Phone (_____)_____

Sample Check