Life Insurance and Personal Accident Insurance Summary
for Chaffey Community College District

**Life Insurance**

Life Insurance provides basic protection for your loved ones if something happens to you. While many U.S. households have life insurance, the average amount of coverage is often inadequate to meet family needs or pay off debt. Taking advantage of life insurance coverage provided by your employer can be an important part of your financial security.

**Program Basics**

- In addition to any Basic Life Insurance Chaffey Community College District may provide, eligible employees may elect more coverage by enrolling in a Suplemental Group Term Life Insurance program.
- Your Basic and Supplemental Life coverage is portable. If you change jobs or retire before the age specified in your certificate, you can keep coverage until age 70 (may vary by state).
- Basic and Supplemental Life Insurance is underwritten by ReliaStar Life Insurance Company, a member of the ING family of companies.

**Coverage Available**

**For You:**

- Elect Supplemental Life coverage from $10,000 to $500,000 in $5,000 increments.
- You are guaranteed $100,000 ($50,000 for 60 or over) of Supplemental Life coverage if you elect it during this initial eligibility period. If you apply for higher amounts of coverage, then you must provide evidence of insurability subject to approval by ReliaStar Life.
- If you elect Supplemental Life coverage outside of this initial eligibility period, then you must provide evidence of insurability subject to approval by ReliaStar Life.
- Benefit amounts reduce to 65% of original coverage at age 70 and to 50% of original coverage at age 75. Refer to your certificate for provisions regarding Termination of insurance.

**For Your Spouse/Domestic Partner:**

- If you are covered for Supplemental Life, you may elect Dependent Spouse/Domestic Partner Life coverage from $5,000 to $250,000 (maximum of 50% of employee’s coverage) in $5,000 increments. Your spouse/domestic partner will need to provide evidence of insurability subject to approval by ReliaStar Life for coverage in excess of $10,000 elected during this initial eligibility period.
- If you elect Dependent Spouse/Domestic Partner Life after you are first eligible, then your spouse/domestic partner must provide evidence of insurability subject to approval by ReliaStar Life.
- Benefit amounts reduce to 65% of original coverage at age 70 and to 50% of original coverage at age 75.
- Dependent Spouse/Domestic Partner coverage terminates when your spouse/domestic partner is no longer a dependent as defined by your certificate of insurance. Refer to your certificate for provisions regarding Termination of dependent’s insurance.

(12/03/2009)
**For Your Children:**
- If you are covered for Supplemental Life, you may apply for Dependent Children Life coverage in amounts of $5,000 or $10,000 on your children age 6 months but less than 19 years, and full-time students less than 25 years.
- The benefit is limited to $500 for children age birth but less than 6 months.
- If you apply for Dependent Children Life when you are first eligible, then no evidence of insurability on your children is required. If you elect Dependent Children Life after you are first eligible, then you must provide evidence of insurability on your children subject to approval by ReliaStar Life.
- Dependent Child coverage terminates when each child is no longer a dependent as defined by your certificate of insurance. Refer to your certificate for provisions regarding Eligibility and Termination of dependent’s insurance.

**Life Insurance Rate Information**

- The rate is based on age at the start of the plan’s current policy year.
- Dependent Child(ren) Life rate is $1.00 per month for $5,000 and $2.00 per month for $10,000 of children coverage.
- Rates shown are guaranteed through 12/31/2011.
- To keep your coverage in force, premiums are payable up to the date of coverage termination.

**How To Use This Chart**

To determine your monthly premium cost:

1. Select the total amount of Supplemental Life coverage you want.
2. Divide by 1,000.
3. Multiply by the rate shown on the chart for your age.

**Example**

Ann Smith is a 35-year-old who applies for $100,000 of Supplemental Life coverage.

She follows these steps for Supplemental Life coverage:

$100,000 divided by 1,000 = $100
$100 times $0.10 = $10.00

Her monthly premium for $100,000 of Supplemental Life coverage is $10.00.

This is a summary of benefits only. A complete description of benefits and limitations will be provided in the certificate of coverage, policy form LP000GP. Underwritten by ReliaStar Life Insurance Company, a member of the ING family of companies.
Personal Accident Insurance

Personal Accident Insurance (PAI) provides additional protection for your loved ones in the event you are killed or severely injured in a covered accident. PAI can help you or your family deal with expenses and financial obligations that arise in the wake of a serious accident.

Program Basics

- Pays additional benefits for a covered accident resulting in the loss of limbs, sight or life. Other losses may also be covered under Chaffey Community College District’s plan.
- Unless otherwise indicated in the certificate, benefits are paid directly to you or your beneficiary.
- Dependent Spouse/domestic partner coverage available (may vary by state).
- Dependent Children coverage available.
- Personal Accident Insurance is underwritten by ReliaStar Life Insurance Company, a member of the ING family of companies.

Coverage Available

For You:

- Elect PAI coverage from $10,000 to $500,000 in $10,000 increments.
- Benefit amounts reduce to 65% of original coverage at age 70 and to 50% of original coverage at age 75. Refer to your certificate for provisions regarding Termination of insurance.

For Your Family:

- If you are covered for PAI, you may elect PAI coverage on your family.
- If both your dependent spouse/domestic partner and dependent children are covered, then dependent spouse/domestic partner coverage will be 50% of your PAI amount and dependent children coverage will be 10% of your PAI amount. If only your dependent spouse/domestic partner is covered, then dependent spouse/domestic partner coverage will be 60% of your PAI amount. If only your dependent children are covered, then dependent children coverage will be 25% of your PAI amount.
- Dependent coverage terminates when your spouse/domestic partner or child is no longer a dependent as defined by your certificate of insurance. Refer to your certificate for provisions regarding Eligibility and Termination of dependent’s insurance.

Exclusions (may vary by state)

No benefit is paid for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. Exception: Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs while committing or attempting to commit a crime.
- Use of any drug, narcotic or hallucinogenic agent –
  - Unless prescribed by a doctor;
  - Which is illegal; or
  - Not taken as directed by a doctor or the manufacturer.
- The insured person's intoxication. Intoxication means an individual's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.
Accidental injury for which the employee has a right to payment under a Workers’ Compensation or similar law.

Accidental injury arising out of or in the course of work for pay, profit, or gain. Exception: This exclusion does not apply to a person who is not covered by Workers’ Compensation and lawfully chose not to be.

**Personal Accident Insurance Rate Information**

The rate is based on age at the start of the plan’s current policy year.

**PAI RATE CHART**
(Cost Per Month/Per $1,000 of Coverage)

<table>
<thead>
<tr>
<th>Employee Only</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.028</td>
<td>$0.056</td>
</tr>
</tbody>
</table>

**How To Use This Chart**

To determine your monthly premium cost:

1. Select the total amount of PAI coverage you want.
2. Divide by 1,000.
3. Multiply by the rate shown on the chart for the category of coverage you elect.

**Example**

Ann Smith elects $100,000 of PAI coverage on herself, and PAI coverage on her family.

She follows these steps for PAI coverage:

- $100,000 divided by 1,000 = $100
- $100 times $0.056 = $5.60

Her monthly premium for PAI coverage is $5.60.

*This is a summary of benefits only. A complete description of benefits and limitations will be provided in the certificate of coverage, policy form HP09GP. Underwritten by ReliaStar Life Insurance Company, a member of the ING family of companies.*
Life and AD&D Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new coverage or any increases in Life coverage will require evidence of insurability (proof of good health) if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

<table>
<thead>
<tr>
<th>Name of Employer/Plan Sponsor</th>
<th>Group/Plan Number</th>
<th>Account Number/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaffey Community College District</td>
<td>66200-3</td>
<td>17</td>
</tr>
</tbody>
</table>

| Class/Occupation | Date of Hire | Annual Salary | Employment Status: | ☐ Active Full-Time | ☐ Retired | ☐ Active Part-Time |

This change is due to: (check all that apply) ___Change in Coverage Amount ___Other: ___________ Effective Date of Coverage or Change: ___________

*Late entrant is an individual who is first enrolling for supplemental or dependent coverage after the first available opportunity.

Employee Information

<table>
<thead>
<tr>
<th>Employee Name (last, first, middle initial)</th>
<th>☐ Female</th>
<th>☐ Male</th>
<th>Date of Birth</th>
<th>Social Security #</th>
<th>Employee I.D. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Address (street address, city, state, zip code)</td>
<td>Telephone</td>
<td>Work ( )</td>
<td>Home ( )</td>
<td></td>
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</tr>
</tbody>
</table>

Employee Life Insurance

Basic Life

☒ Employee Only—Elect Coverage (Note: Basic Life insurance is employer provided.)

Supplemental Life

Guaranteed Issue (GI) Limit = $100,000 ($50,000 age 60 and over). When you are first eligible for Supplemental Life coverage, you can elect up to the GI limit without evidence of insurability. Total Supplemental Life coverage up to $500,000 is available if you complete an Evidence of Insurability form subject to approval by ReliaStar Life.

Supplemental Life Election

I currently have Supplemental Life coverage of: $ _______.

I am applying for additional Supplemental Life coverage of: $ _______. ($5,000 increments)

Total Supplemental Life coverage (current plus additional): $ _______.

Employee Basic and Voluntary Accidental Death & Dismemberment (AD&D) Insurance

Basic AD&D

☒ Employee Only—Elect Coverage (Note: Basic AD&D insurance is employer provided.)

Voluntary AD&D

Elect PAI coverage from $10,000 to $500,000 in $10,000 increments.

Voluntary AD&D Election

I currently have Voluntary AD&D coverage of: $ _______.

I am applying for additional Voluntary AD&D coverage of: $ _______. ($10,000 increments)

Total Voluntary AD&D coverage (current plus additional): $ _______.

Beneficiary Information

Designate your beneficiary(ies) below.

<table>
<thead>
<tr>
<th>Name of Beneficiary (last name, first, middle initial)</th>
<th>☐ Primary</th>
<th>☐ Contingent</th>
<th>Relationship to Employee</th>
<th>Benefit %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Date of Birth</td>
<td>Social Security Number</td>
<td>Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Beneficiary (last name, first, middle initial)</th>
<th>☐ Primary</th>
<th>☐ Contingent</th>
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<td>Social Security Number</td>
<td>Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Beneficiary (last name, first, middle initial)</th>
<th>☐ Primary</th>
<th>☐ Contingent</th>
<th>Relationship to Employee</th>
<th>Benefit %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Date of Birth</td>
<td>Social Security Number</td>
<td>Phone Number</td>
<td></td>
</tr>
</tbody>
</table>
Dependent Spouse/Domestic Partner (DP) Life Insurance

Spouse/DP Life

Date of Birth __/__/____
Name ____________________________

When you are initially eligible for Dependent Spouse/DP Life coverage, you can elect up to $10,000 in coverage without evidence of insurability. Total Spouse/DP Life coverage up to $250,000 is available if your spouse/DP completes an Evidence of Insurability form subject to approval by ReliaStar Life. Dependent Spouse/DP Life coverage is limited to 50% of the employee's coverage amount.

Spouse/DP Life Election $__________ (5,000 increments) □ Waive

Note: The employee is the beneficiary for any dependent spouse/DP insurance coverage.

Dependent Child(ren) Life Insurance

Child(ren) Life

When you are initially eligible for Dependent Child(ren) Life coverage, you can elect it without evidence of insurability. At all other times, you must complete an Evidence of Insurability form for your child(ren) subject to approval by ReliaStar Life. Child(ren) age birth to 6 months of age are covered for $500.

Child(ren) Life Election □ $5,000 for each eligible dependent child. □ $10,000 for each eligible dependent child. □ Waive

Note: The employee is the beneficiary for any dependent child(ren) insurance coverage.

Dependent Accidental Death & Dismemberment Insurance

Voluntary Dependent AD&D

Voluntary Dependent AD&D coverage is limited to a percentage of the employee's Voluntary AD&D coverage amount.

Voluntary Dependent AD&D Election □ Spouse/Domestic Partner Only □ Child(ren) Only □ Spouse/Domestic Partner & Child(ren)

Amount equal to 60% of employee's coverage Amount equal to 25% of employee's coverage Spouse/domestic partner equal to 50% of employee's coverage; child(ren) equal to 10% of employee's coverage

Note: The employee is the beneficiary for any dependent insurance coverage.

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee’s Signature ____________________________ Date Signed __/__/____

Underwritten by ReliaStar Life Insurance Company

GATGI (02/08)
Evidence of Insurability Instructions

1. This Evidence of Insurability (EOI) form should already have your Employer’s Name and the Group Number(s) preprinted on it. If this is not the case, check with your Benefits Person regarding your plan’s Group Number. We cannot process your request for coverage without your Group Number.

2. If you are applying for Life coverage, your Benefits Person should indicate your current amount, the total amount you are requesting (including your current amount and any guaranteed amount, if applicable) and the amount that needs to be medically underwritten on the EOI form or should give you instructions regarding what these amounts should be. If you have a question regarding the amount that requires underwriting, please contact your Benefits Person in your Human Resources Department.

IMPORTANT:

The “amount to be underwritten” is the dollar amount of coverage for which you or your dependents must show proof of good health. This “underwritten” amount should not include any coverage you or your dependents may already have in force through this plan or any coverage that can be obtained through this plan without providing evidence of insurability. If the amount to be underwritten is incorrectly stated on your EOI form, you or your spouse may be asked to have an exam, blood profile or EKG that might otherwise not be necessary. Note: If there is no current coverage in force, state “0” in that column. Current, total and underwritten amounts need only be indicated on this EOI form for the family members who are applying for coverage at this time. If not applying, the amounts in these columns can be left blank.

3. Make sure that you give us all of the requested information. Answer all questions. Sign and date both sides of the Evidence Form at the bottom. Failure to do so may result in having your Evidence Form returned to you for completion and will definitely delay processing time for your request.

4. Complete both sides of the Evidence Form.

5. Indicate the full names and complete mailing addresses of the physicians listed. Attach an additional sheet, if necessary. Complete mailing addresses will greatly reduce processing delays.

6. Make and keep a copy of both sides of the Evidence Form for your records.

7. Read the “ReliaStar Life Insurance Company Insurance Information Practices Notice” (on the other side of these instructions) and keep it for your reference.

8. After completing your Evidence Form, follow the instructions given to you by your Benefits Person. They may request that you return your completed Evidence Form to your HR department or send it to your plan’s Third Party Administrator, if applicable, or mail your Evidence Form directly to ReliaStar at the address on the top right corner of the Evidence of Insurability Form.

9. For general questions regarding completing this form or for checking the status of your underwriting once the EOI form has been submitted to ReliaStar, please call Medical Underwriting at (612) 342-7262. However, you must contact your Benefits Department if you have a question regarding amounts. Medical Underwriting does not have information concerning the amounts that should be indicated on your EOI form.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
ReliaStar Life Insurance Company
Insurance Information Practices Notice

We are pleased to provide you with information regarding this Evidence Form. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Evidence Form, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information
Your Evidence Form is our main source of information. But we may:
- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See “Notice Regarding MIB, Inc.” below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.
We or our reinsurers 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 an 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 file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB’s file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB’s phone number is 866-692-6901 (TTY 866 346-3642). 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 for benefits may be submitted.
Evidence of Insurability

ReliaStar Life Insurance Company
P.O. Box 20, Route 7812, Minneapolis, Minnesota 55440

ALL INFORMATION IN THE BOLD BOXES MUST BE COMPLETED. FOR QUESTIONS REGARDING PROPER AMOUNT TO BE UNDERWRITTEN, CONTACT YOUR HR BENEFITS PERSON. Please type or print in ball point pen.

<table>
<thead>
<tr>
<th>Employee’s Social Security Number</th>
<th>Employee’s Name (Please Print)</th>
<th>Employee’s Date of Birth</th>
<th>Employee’s Sex</th>
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<tbody>
<tr>
<td></td>
<td>Last</td>
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<td>M or F</td>
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<td>First</td>
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<td></td>
<td>Middle</td>
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<table>
<thead>
<tr>
<th>Group Number</th>
<th>Acct. No.</th>
<th>Name of Employer</th>
<th>Hire Date (Full-time)</th>
<th>Employee’s Job Title</th>
<th>Annual Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>66200-3</td>
<td>17</td>
<td>Southern California Schools Employee Benefits Association</td>
<td>/ / /</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chaffey Community College District</td>
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</tbody>
</table>

For life coverages: Enter the dollar amount of current coverage (including any guaranteed amount, if applicable), the total dollar amount desired and the dollar amount of the difference between the total amount desired and the current amount which requires proof of good health at this time (i.e. needs to be medically underwritten).

<table>
<thead>
<tr>
<th></th>
<th>Current Amount</th>
<th>Total Amount Desired</th>
<th>Amount to be Underwritten</th>
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</thead>
<tbody>
<tr>
<td>Employee</td>
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<tr>
<td>□ Supplemental Life</td>
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<tr>
<td>Spouse</td>
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<tr>
<td>□ Supplemental Life</td>
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<tr>
<td>Child(ren): □ Supplemental Life</td>
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</table>

This EOI submitted due to: □ Initial Enrollment □ New Hire □ Late Entrant □ Increase □ Other – Explain: ______________________

Employee’s Home Address (Please Print)

<table>
<thead>
<tr>
<th>Complete Street Address (Include Apt. #, PO Box #, RFD, etc.)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Employee Home Phone #: ________________________  Employee Work Phone #: ________________________
(________) Ext.  Name: ____________

Now, complete all the following information:
List below only the names of persons who must show proof of good health for coverage that needs to be underwritten as indicated above. NOTE: If you are requesting coverage for a step-child or a child over age 18, please check with your Benefits person to make sure the child would qualify as an eligible Dependent under the contract terms of this plan.

<table>
<thead>
<tr>
<th>Names of persons to be underwritten at this time. Please print full name.</th>
<th>Relationship to employee</th>
<th>Birthdate (mm, dd, yr.)</th>
<th>Present Height (ft.) (in.)</th>
<th>Present Weight (pounds)</th>
<th>Regular physician(s) – provide name and complete mailing address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>SELF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
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<tr>
<td>Child</td>
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<tr>
<td>Child</td>
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</table>

IMPORTANT! Please carefully read the next section. Then sign and date below.
I request the coverage indicated above on this Evidence Form under the Group Plan(s) sponsored by my Employer and authorize the required deduction, if any, from my wages. I declare that all of the statements and answers on both sides of this Evidence Form are complete and true to the best of my knowledge and belief. I agree that they shall be the basis for issuance of coverage under my Employer’s Group Plan(s). I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company’s Home Office will not be valid. I certify that I have a copy of both sides of this Evidence Form to keep for my records.

Date: ____________  Employee’s Signature (required): ________________________

*COMPLETE ALL MEDICAL INFORMATION ON BACKSIDE*
NOTE: Answer Questions #1-7 below only as they pertain to the person(s) requesting coverage AT THIS TIME.

For each “yes” answer, state information below. (Please attach a separate sheet if additional space is needed.)

1. □ Yes □ No Has any person requesting coverage ever had or been treated for any of the following? Lung disorder; asthma; high blood pressure; heart trouble; nervous disorder; liver or stomach disorder; kidney or urinary disorder; diabetes; arthritis; cancer; alcohol/chemical abuse; depression; or any physical/mental impairment.

2. □ Yes □ No In the last three years, has any person requesting coverage had or been treated for any of the following? Ulcer; back/neck trouble; eye or ear impairment; any disorder or disease of the breasts, reproductive system or prostate; carpal tunnel syndrome; or knee disorder.

3. □ Yes □ No Has any person requesting coverage consulted a physician, received surgical or medical care or taken prescribed medication for any condition during the past 12 months (including current treatment)?

4. □ Yes □ No Does any person requesting coverage anticipate being under a doctor’s care for any condition within the next 6 months?

5. □ Yes □ No Has any person requesting coverage had or been told they had, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?

6. □ Yes □ No Has any person requesting coverage been previously declined by ReliaStar Life or any other insurance company?

7. □ Yes □ No Is any person requesting coverage currently pregnant? Expected due date:

<table>
<thead>
<tr>
<th>Q #</th>
<th>Name of family member</th>
<th>Condition/illness/injury-type of treatment</th>
<th>Date of Treatment</th>
<th>Physician’s name and complete mailing address (include your medical or clinic ID number if any)</th>
</tr>
</thead>
<tbody>
<tr>
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Authorization and Acknowledgment — Please read and sign below.

For underwriting and claims 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 (MIB), Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including 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 as they apply to me, my spouse or any of my children who are 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 disclosure 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 -- 42CFR Part 2. 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.

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, Inc. 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 Insurance Information Practices Notice and Notice Regarding MIB, Inc. (on back of the Evidence of Insurability Instructions).

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<th>Date</th>
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