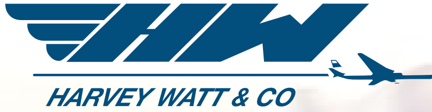


AVIATION HEALTH ASSOCIATION GROUP TERM LIFE INSURANCE

Underwritten by ReliaStar Life Insurance Company, A Member of the VOYA® Family of Companies

Dear Pilots,

We are pleased to provide you with the opportunity to enroll in the Aviation Health Association-sponsored Group Term Life Insurance Program. In the past, many pilots have expressed a need to add to their life insurance program through a quality association group plan. Perhaps, you should take a few moments to consider this important benefit.

Some of the reasons why you should consider enrolling are outlined in the enclosed brochure. They include a high limit of coverage at very competitive rates, availability of coverage for your spouse and children, and a special conversion option.

Many financial planners suggest that Term Life Insurance is a most economical way to maintain an up-to-date insurance program. The enclosed brochure contains detailed information about this group program. Please take a few moments to read through it and if you have any questions, give us a call at: (800) 241-6103.

Why not take advantage of this benefit by applying today and providing your loved ones with the protection they deserve. To apply, complete the enclosed application and mail it in the convenient pre-addressed envelope.

Sincerely,

Robin Alston
Harvey Watt & Company

Protect Your Family's Future With Affordable Group Life Insurance

Underwritten by ReliaStar Life Insurance Company for FAA Licensed Pilots who are members of The Aviation Health Association.

Save Three Ways With ReliaStar

As an FAA Licensed Pilot and a member of the Aviation Health Association, you have the opportunity to enroll in a special group term life program and realize savings in three important ways:

1. Term insurance offers the most protection at an economical cost.
2. You get ReliaStar's economical group rates as an FAA Licensed Pilot and member of the Aviation Health Association.
3. You can get the similarly economical rates on coverage for your spouse and children.

Why Do I Need Life Insurance?

If you have anyone who depends on your income, you need life insurance. It can take care of your dependents' financial need even if you're not around. Your family can use the benefits to help:

- provide a continuous source of income;
- assure your children's higher education;
- pay off the mortgage on your house;
- settle any other outstanding debts;
- pay for final expenses.

These days, when so many families depend on two incomes to make ends meet, the need for insurance on both wage earners is more important than ever. And even if one spouse is a homemaker, replacing child and home care services takes money as well.

What If I Already Have Some Life Insurance?

Then you understand how important this kind of protection really is. But you may want to take another look at how much coverage you have. Your needs may have changed since you first bought that policy. For example, your income, personal debt or family size may have increased. Experts say that you should have at least seven to ten times your annual income in life insurance.

If you need to supplement the insurance you already have, this plan offers an affordable and convenient way to do so.

Your Plan of Benefits

As an FAA Licensed Pilot under age 65 who resides in the United States, you can apply for up to $1,500,000 of coverage on yourself and coverage for your dependent children from 15 days to 21 years of age (25 if a full-time student). Your spouse under age 65 can also apply for up to $1,500,000 of coverage, even if you are not participating in the plan.

If both you and your spouse are eligible members, only one member may request coverage for your eligible children.

Life Benefits And Rates

Benefits are paid for death occurring at any time, any place, from any cause, except suicide in the first two years of coverage.

The monthly cost for you and your spouse varies by age. The monthly cost will increase as your or your spouse reach the next age bracket. The monthly premium rates are outlined below.

Monthly Rate per $1,000 of Coverage				
	Pilot		Spouse	
Attained Age	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Under 30	$ .056	$ .028	$ .056	$ .037
30 - 34	.056	.033	.056	.037
35 - 39	.074	.042	.074	.047
40 - 44	.121	.066	.121	.074
45 - 49	.205	.093	.205	.112
50 - 54	.335	.167	.335	.205
55 - 59	.521	.260	.521	.260
60 - 64	.632	.353	.632	.353
65 - 69*	1.702	.949	1.702	.949
You can purchase up to $1,500,000 of coverage, but not less than $25,000 of coverage for you or your spouse.				
Monthly Premium for $10,000 of Coverage for Dependent Children $2.00 per Family				
Dependent children are eligible if they are between the ages of 15 days and 25 years. However, children must be attending an accredited college or university on a full-time basis from age 21 to 25, and be wholly dependent on the employee for support in order to remain eligible for this coverage.				

Example for Non-Tobacco Users: You are 42 and select $250,000 of life insurance. Your spouse is 38 and selects $150,000 of life insurance. You insure your three children for $10,000. Your monthly premium is $25.55.						
Employee	=	250	x	.066	=	16.50
Spouse	=	150	x	.047	=	7.05
Children	=			2.00	=	2.00
TOTAL	=					**25.55**

Rates are guaranteed for first year of coverage. Coverage reduces to the lesser of $50,000 or 50% at age 65; that amount will reduce by 50% at age 70 and further reduces by 50% at age 80. Spouse coverage will reduce to the lesser of $25,000 or 25% at age 70; spouse coverage terminates at age 75.

Includes More Special Features

- No Cancellation for ill Health - once your coverage takes effect, you cannot be canceled due to a change in your health.
- Conversion Privilege - If coverage is terminated, conversion to an individual whole life policy is allowed, without proof of good health.
- 30 Day Free Look - you have 30 days to look over your plan of insurance and discuss it with your family and advisors. If for any reason you're not satisfied, you may return your certificate within 30 days of receipt for a full refund.

Term Of Coverage

Your coverage will go into effect on the first day of the month following approval of your application, provided you pay the required premium.

If you choose to cover your dependents, their insurance will begin on the date you become covered, or the first of the month following approval of your application to cover a dependent, whichever is later, provided the required premium is paid.

If you or your spouse are not actively at work when coverage would normally take effect, the effective date will be deferred until the first of the month after you or your spouse have worked full-time for 90 consecutive days.

If you or your spouse are unemployed and unable to carry out the normal and customary activities of a healthy person of the same age and sex, coverage will be deferred until the first of the month following your being able to carry out those activities for 90 consecutive days.

Any effective date of coverage is subject to the applicant's health remaining unchanged from the date of application.

Coverage for you or your insured spouse will remain in force unless:

- your premiums are not paid;
- you reach the limiting age of the policy;
- the master policy is canceled.

Your dependents coverage remains in force as long as your coverage remains in effect, premiums are paid when due and they remain eligible dependents.

Exclusion

Suicide is excluded from coverage for two years from the effective date of each person's coverage. However, if suicide is committed during the first two years, we will refund the premiums paid to the date of the death.

Here's How To Apply

1. Complete the enclosed application, answering all questions fully. Be sure that you and your spouse, if applying, each complete, date and sign a separate application.
2. Mail the completed application and payment authorization form along with a voided check in the enclosed, self-addressed envelope - today!

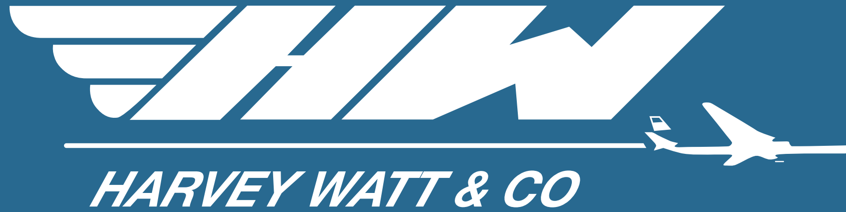
Coverage cannot become effective until ReliaStar Life Insurance Company grants its underwriting approval. You do not receive temporary or conditional insurance coverage just because you submit an application and pay the first premium.

If you have any questions regarding the plan, application or claims, contact the plan administrator.

Administered by:
Harvey Watt & Company
P.O. Box 20787, Hartsfield-Jackson International Airport
Atlanta, GA 30320-0787
(800) 241-6103 or (404) 767-7501

Underwritten by:
ReliaStar Life Insurance Company
Minneapolis, MN

This program is not available in all states or any foreign countries. Coverage may vary in some states. Please contact the plan administrator for details. This brochure is a summary of benefits only and is subject to the terms, conditions and limitations of Group Policy No. 65009-9 (Policy form LP00GP).



Administered by:

Harvey W. Watt & Co.
AHA GROUP INSURANCE PLANS
PO Box 20787, Atlanta Airport
Atlanta, Georgia 30320
Call Toll Free: (800) 241-6103
www.harveywatt.com

Underwritten by:

ReliaStar Life Insurance Company
(a member of the VOYA family of companies)

This information is a brief description of benefits only and is subject to the terms, conditions and limitations set forth in Group Policy number 65009-9 (Policy form LP00GP). The Group Policy is subject to the laws and jurisdiction of the state in which it is issued. Additional information is contained in the Certificate of Insurance which is issued to the persons who become insured under the plan.

The availability of this offer may change and coverage may not be available in all states. Please keep this material as a reference for filing with your Certificate of Coverage.

Here’s How to Apply

1. Print an application package for you, the Member, and your Spouse (if applying for Spouse coverage).

2. Complete the Application for Membership in the Aviation Health Association.

3. Complete the 2-page Group Term Life Application and sign and date the application.

4. Complete payment authorization (if you and your spouse apply for coverage, you only need to complete one copy of this form).
   - Complete and sign form.
   - Write void across a blank check and attach.

5. Mail all of the above to:

   Harvey W. Watt & Co – Life Insurance

   PO Box 20787

   Atlanta GA 30320

   Or fax all of the above to: (404) 761-8326

Note:

- If additional information or underwriting is required, you will be notified by Harvey W. Watt & Co.
- Please call us 1-800-241-6103 or send an email to pilot@harveywatt.com if you have questions.

APPLICATION FOR MEMBERSHIP IN THE AVIATION HEALTH ASSOCIATION

THE AVIATION HEALTH ASSOCIATION is an organization whose purpose is to promote the welfare and best interests of its members; to assemble and distribute information related to the health and safety of professionals in the airline industry; and to enhance social and economic conditions for its members through cooperative enterprises as a professional or commercial association. One of the benefits of membership is eligibility for group insurances. If you are not already a member of the Aviation Health Association, complete the application below.

I hereby make application for membership in the Aviation Health Association. I certify that I currently hold a valid FAA Medical Certificate that was not obtained by misstatement or concealment and that I am currently employed as a pilot or flight engineer as my primary occupation.

Date: ___________________________

Printed Full Name: ____

Address: ____ City:_____________________________ State/Zip:__________________

Signed: ____

Return to:
Harvey W. Watt & Co.
P.O. Box 20787
Atlanta, GA 30230

Attach Voided Check

AUTHORIZATION FOR PREMIUM PAYMENTS

Here's how to use the Pre-Authorization Premium Payment Plan:

1. Complete and sign the Membership Premium Payment Authorization form.
2. Write VOID across one of your blank checks.
3. Enclose the Membership Premium Payment Authorization form and the voided check, along with your completed application, in the postage paid envelope provided and mail it to Harvey Watt & Company.

That's all there is to it. Your monthly premiums will be paid automatically, electronically. There's nothing more for you to do but to enjoy all the security of this plan.

☐ Check here if you prefer Annual Billing. (Monthly premium x 12)
Annual invoices are mailed to the address on file.

MEMBERSHIP PREMIUM PAYMENT AUTHORIZATION FORM

AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS (ACH DEBITS) TO HARVEY W. WATT & CO.
FOR PREMIUMS DUE ON PILOT OCCUPATIONAL DISABILITY AND/OR LIFE INSURANCE

I (we) hereby authorize HARVEY W. WATT & CO. to initiate debit entries to my (our) Checking or Credit Union draft account indicated below and the bank or credit union named below, hereinafter called DEPOSITORY, to debit the same to such account.

DEPOSITORY NAME ____ BRANCH ____

CITY ____ STATE _________________ ZIP _____________________

TRANSIT/ABA NO. ____ ACCOUNT NO. ___________________________________

This authority is to remain in full force and effect until HARVEY W. WATT & CO. and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford Harvey W. Watt & Co. and DEPOSITORY a reasonable opportunity to act on it. I (or either of us) have the right to stop payment of a debit entry by notification to DEPOSITORY at such time as to afford DEPOSITORY a reasonable opportunity to act on it prior to charging my (our) account. After account has been charged, I have the right to have the amount of the erroneous debit immediately credited to my account by DEPOSITORY, provide I (we) send written notice of such debit entry in error to DEPOSITORY within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first.

I (we) further agree that any requirement for giving notice of premiums due shall be waived as long as the authorization agreement is in effect. The debit as shown on my (our) bank or credit union account statement will constitute a receipt for the premium, but no premium or portion thereof shall be deemed to have been paid unless and until Harvey W. Watt & Co. receives actual payment at its Home Office. The use of this premium payment shall in no way alter or amend the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

NAME ____ EMPLOYMENT ID# ________________________________

PLEASE PRINT

DATE ______________________________ SIGNED X ____

SIGNED X ____

Group Term Life Application

Please complete the entire application to apply for coverage in the Group Term Life plan with 5-year age bracketed rates. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to* ***Harvey Watt & Company, PO Box 20787, Atlanta, GA 30320-0787. Phone: 800-241-6103 or 404-767-7501. Fax: 404-761-8326.***

Aviation Health Association **Group Policy No. 65009-9 acct 2**

1. TELL US ABOUT YOURSELF

Member's Information ***(complete this section only if applying for Member coverage on this application)*****:**

Name (Last, First, M.I.)			❑ Male ❑ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Spouse of Member's Information ***(complete this section only if applying for Spouse of Member coverage on this application)*****:**

Name (Last, First, M.I.)		Name of Member	❑ Male ❑ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Dependent Child(ren)'s Information ***(complete this section only if applying for Dependent Child(ren) on this application)*****:**

Number of eligiblechildren:___________ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below

Name________________________________ DOB__________________ SSN__________________

Name________________________________ DOB__________________ SSN__________________

Name________________________________ DOB__________________ SSN__________________

Name________________________________ DOB__________________ SSN__________________

Address	City	State	Zip

	Member	Spouse
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
b) Are you currently working less than 30 hours per week at your regular occupation and place of business?	❑ Yes ❑ No	❑ Yes ❑ No
c) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	❑ Yes ❑ No	❑ Yes ❑ No

If yes, please explain:____

2. SELECT YOUR COVERAGE

Member Amount

❑ $_____________ *($25,000 to $1,500,000 in increments of $5,000)*

Spouse of Member Amount

❑ $______________ *($25,000 to $1,500,000 in increments of $5,000)*

Please select if you wish to include additional options with your coverage: ❑ $10,000 Dependent Child(ren) Coverage*

** If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.*

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION

Member: **Height______ft. ______in. Weight______lbs.** Spouse of Member: **Height______ft. ______in. Weight______lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member:____ Spouse:____

____ ____

	Member	**Spouse**
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? …………	❑ Yes ❑ No	❑ Yes ❑ No
2) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack) , sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?…………	❑ Yes ❑ No	❑ Yes ❑ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?…………	❑ Yes ❑ No	❑ Yes ❑ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?…………	❑ Yes ❑ No	❑ Yes ❑ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?…………	❑ Yes ❑ No	❑ Yes ❑ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?…………	❑ Yes ❑ No	❑ Yes ❑ No
3) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?…………	❑ Yes ❑ No	❑ Yes ❑ No
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?…………	❑ Yes ❑ No	❑ Yes ❑ No
5) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?…………	❑ Yes ❑ No	❑ Yes ❑ No
6) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?…………	❑ Yes ❑ No	❑ Yes ❑ No

a. Member's driver's license number and state of issue:____________________________
b. Spouse's driver's license number and state of issue:____________________________

	Member	**Spouse**
7) Have you ever applied for insurance that was declined, postponed or modified in any way?…………	❑ Yes ❑ No	❑ Yes ❑ No
8) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?…………	❑ Yes ❑ No	❑ Yes ❑ No

For every "Yes" answer to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	❑Member ❑Spouse of Member				
	❑Member ❑Spouse of Member				
	❑Member ❑Spouse of Member				
	❑Member ❑Spouse of Member				
	❑Member ❑Spouse of Member				
	❑Member ❑Spouse of Member				

PLEASE COMPLETE AND SIGN END OF APPLICATION

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Member Coverage ***(complete this section only if applying for Member coverage on this application)***

Name (Last, First, M.I.)			
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Name (Last, First, M.I.)			
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Beneficiary for Spouse of Member Coverage ***(complete this section only if applying for Spouse of Member coverage on this application)***

Name (Last, First, M.I.)			
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Name (Last, First, M.I.)			
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

5. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

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

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

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

PLEASE COMPLETE AND SIGN END OF APPLICATION

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Member's Signature	Date	Spouse of Member's Signature (if applying)	Date

---

Owner of Member Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.)		Date of Birth (MM/DD/YYYY)	Social Security Number
Address	City	State	Zip
Owner's Signature			Date

Owner of Spouse of Member Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.)		Date of Birth (MM/DD/YYYY)	Social Security Number
Address	City	State	Zip
Owner's Signature			Date

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION *(HIPAA compliant)*

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(Please print.)* ______________________________

Birth Date ____________________ SSN/ITIN ____________________

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/Carrier(s)).*

Authorized Life Insurance Carrier(s): ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York and Security Life of Denver Insurance Company

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 authorize any organization, insurance company or medically related facility to release to the Life Insurance Carrier named above any and all records and information regarding me, the proposed insured, and any minor children who are to be insured according to the terms of this authorization. This includes 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 or prescription records; (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, pharmacy benefit manager, 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 Insurance Agent/Agency/Carrier(s) 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. I authorize MIB, Inc. to give to the Life Insurance Carrier(s) named above, or its reinsurers, any records or knowledge of me or my health.

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 Insurance Agent/Agency/Carrier(s) 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 Insurance Agent/Agency/Carrier(s).

I give my permission to the Life Insurance Carrier named above to send any information obtained to MIB, Inc. or its reinsurers.

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 Insurance Agent/Agency/Carrier(s) named above at the following address: Attention: Privacy Official, 2000 21st Ave. NW, Minot, ND 58702

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 any applicable state privacy laws, 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.

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. 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. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, 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 application or claim 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.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. 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, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. 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 us. 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; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

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.