

EVIDENCE OF INSURABILITY (MN)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya family of companies
PO Box 20, Mail Stop 5-E, Minneapolis, MN 55440
Phone: 612.342.7262 Fax: 612.467.8721



Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number _____ Account Number _____ Employer Name _____

A. EMPLOYEE INFORMATION

Employee Name (First, MI, Last) _____ Gender: Male Female

SSN _____ Personal E-mail Address _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Home Phone (_____) _____ Cell Phone (_____) _____

Hire Date _____ Salary \$ _____ Occupation _____

Primary Health Practitioner _____ Practitioner Phone (_____) _____

Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS (Complete this table based only on the coverage you have through this plan.)

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? Yes No

| Coverage Type | (A) Total Amount Desired | (B) Current Amount | (C) Guaranteed Issue Amount | (A) – (B) – (C) = Amount To Be Underwritten |
|---|-----------------------------|-----------------------|--------------------------------|--|
| <input type="checkbox"/> Employee Supplemental Life | \$ | \$ | \$ | \$ |
| <input type="checkbox"/> Spouse Supplemental Life | \$ | \$ | \$ | \$ |

C. SPOUSE INFORMATION

Spouse Name (First, MI, Last) _____ Gender: Male Female

SSN _____ Personal E-mail Address _____ Birth Date _____

Home Phone (_____) _____ Cell Phone (_____) _____

Same Primary Health Practitioner as Employee (See information above.)

Primary Health Practitioner _____ Practitioner Phone (_____) _____

Practitioner Address _____ City _____ State _____ ZIP _____

D. EMPLOYEE AND SPOUSE HEALTH QUESTIONS *(Must be answered for coverage that is not Guaranteed Issue.)*

The applicant does not have to disclose a test, or the results of a test, (1) to detect the presence of the HIV virus, which was administered under state law to a criminal offender or as a result of a crime that was reported to law enforcement officials; or (2) to detect the presence of a bloodborne pathogen, which was administered under state law to (a) an emergency medical services person as a result of significant exposure to a source individual; (b) an inmate as a result of a significant exposure involving a corrections employee, or (c) a patient as a result of a significant exposure involving an employee of a secure treatment facility. Please see authorization section for definitions.

| Employee (EE) | | Spouse (SP) | | |
|--|--------------------------|--------------------------|--------------------------|---|
| Yes | No | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. To the best of your knowledge have you ever been treated for or been medically diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. To the best of your knowledge have you ever had, or been treated for or medically diagnosed with, any of the following by a member of the medical profession: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient? |
| Complete for EE and SP. ---> | | | | 3. Employee: Height _____ ft. _____ in. Weight _____ lbs. Spouse: Height _____ ft. _____ in. Weight _____ lbs. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. To the best of your knowledge in the past 10 years have you consulted with, been diagnosed or treated by a member of the medical profession, or taken medication for any of the following: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Polycystic kidney disease or kidney failure? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. To the best of your knowledge have you ever been diagnosed, treated or given medical advice by a member of the medical profession for: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | a. Chest pain, heart trouble or circulatory disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Anemia or leukemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Sleep apnea, asthma or other respiratory disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Stomach disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | f. Brain or seizure disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | g. Mental or nervous disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | h. Arthritis, paralysis or any muscle weakness? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | i. Abnormal urine specimen or urinary tract disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | j. Prostate or other reproductive organ disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. To the best of your knowledge are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. To the best of your knowledge do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition, disease not shown above? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. To the best of your knowledge 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 the use of such substances? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. To the best of your knowledge in the past 2 years have you experienced any symptom(s) for which you have not yet consulted member of the medical profession, or are any medical, surgical or diagnostic procedures recommended or contemplated? |

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

| Question Number | Applicant | Description of Condition | Date Condition Began | Description of Treatment Received | Fully Recovered? | Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone |
|-----------------|--|--------------------------|----------------------|-----------------------------------|---|--|
| | <input type="checkbox"/> EE <input type="checkbox"/> SP | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | <input type="checkbox"/> EE <input type="checkbox"/> SP | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | <input type="checkbox"/> EE <input type="checkbox"/> SP | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Employee Name _____ SSN (Last 4 digits only) _____

E. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization 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). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described 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 permission as it applies to any information protected by 42 CFR Part 2 at any time. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further 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. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence form to keep for my records. This authorization will be valid as long as I am continually insured with ReliaStar Life or 12 months, whichever is less.


I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

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

IMPORTANT! Please carefully read the next section. Then sign and date below.

I acknowledge that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

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.

 Employee Signature _____ Date _____

 Spouse Signature _____ Date _____

Submit your EOI form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: 1-612-467-8721

Or

Mail to: ReliaStar Life Insurance Company, PO Box 20, Mail Stop 5-E, Minneapolis, MN 55440

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

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Security Life of Denver Insurance Company, Denver, CO
Members of the Voya® family of companies
(the "Company")

PROPOSED INSURED INFORMATION (Please print.)

Proposed Insured Name (First) _____ (Middle Initial) _____ (Last) _____

Birth Date (mm/dd/yyyy) _____

AUTHORIZATION INFORMATION

This will authorize a physician, clinic or hospital to release medical information to the Life Insurance Carrier(s) named above (the "Company"), or its reinsurers.

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 (the "Company"), 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 Signature _____ Date (mm/dd/yyyy) _____

➡ Authorized Signer (if Proposed Insured is a minor) _____ Date (mm/dd/yyyy) _____

Description of Personal Representative's Authority or Relationship to Proposed Insured:

Attorney in Fact Grandparent Guardian Parent Other _____

A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PROPOSED INSURED.

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the *Voya*® family of companies



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.