INDIVIDUAL TERM LIFE INSURANCE APPLICATION

ReliaStar Life Insurance Company
[20 Washington Avenue South, Minneapolis, MN 55401]
[*A member of the ING family of companies*]
(the "Company")

This application may not be used if the policy to be purchased is or may be used for the benefit of a third party (a "stranger") that lacks an insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company does not issue policies for stranger-owned / stranger originated life insurance transactions ("STOLI") and shall seek to void any such policy. You agree that the Company will retain any premiums paid as special damages and may seek recovery of costs and/or additional damages. Material misrepresentation regarding the facts presented to the Company for underwriting the application or attempts to defraud the Company may result in additional legal action. Please see Section P of the application.

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

1. Product Requested _____ 2. Face Amount $ _____

3. Initial Term Period *(Term period options vary by product.)*:

☐ 10 Year ☐ 15 Year ☐ 20 Year ☐ 25 Year ☐ 30 Year ☐ Other _____

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

☐ Accidental Death Benefit Rider *(Specify amount.)* $ _____
Note: This rider is not the automatic Accelerated Benefit Rider (ABR).

☐ Children's Insurance Rider
(Complete Children's Insurance Rider Application.)

☐ Waiver of Premium Rider
☐ Other _____
☐ Other _____
☐ Other _____

C. PROPOSED INSURED INFORMATION

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

D. OWNER *(Questions 1-7 are required when the Proposed Owner is different than the Proposed Insured. Also complete 8-9 if the owner is a corporation, or 10-13 if the owner is a trust.)*

1. Full Name of Owner *(30 character limit)* _____
2. Owner Relationship to Proposed Primary Insured _____ 3. E-mail _____
4. Owner Birth Date _____ Owner Phone (_____)_____ Owner SSN _____
5. Owner Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
6. Billing Address _____ City _____ State _____ ZIP _____

D. OWNER *(Continued)*

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

   Issuing State or Country _____ Issuance Date _____ Expiration Date _____

If the owner is a corporation, complete questions 8-9.

8. Corporation Contact Name _____ TIN _____

9. Corporation Signing Officer Name / Title _____ State of Incorporation _____

If the owner is a trust, complete questions 10-13. Provide a copy of the full Trust document or complete the Trust Certification. *(The Trust must be established prior to the application date.)*

10. Trustee Contact Name _____ TIN _____ Trust Date _____

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

12. Trustee / Trustees Name *(List all)* _____ Situs State / State of Incorporation _____

13. Does the trustee (or each trustee if more than one) have sole authority to bind the Trust? ☐ Yes ☐ No *(If "No," state the conditions under which one or more trustees may bind the trust. List the addresses of all trustees on a separate page, and obtain signatures from all trustees on the application.)*

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

1. Payor Name _____

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

F. BENEFICIARY INFORMATION *(Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)*

Individual as a Beneficiary *(Complete the table below.)*

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

Trust or Business/Corporation as a Beneficiary *(Complete the table below. If the beneficiary is a trust, provide a copy of the full Trust document or complete the Trust Certification.)*

Trust or Business / Corporation Name	Trust Date	Situs State / State of Incorporation	%	Beneficiary Type
				☐ Primary ☐ Contingent
				☐ Primary ☐ Contingent

G. PROPOSED INSURED PERSONAL HISTORY

1. Are you, or have you entered into a written agreement to become, a member of the armed forces, including the Reserves, or on alert? *(If "Yes," complete Military Questionnaire.)* . . . . . ☐ Yes ☐ No
2. Do you intend to travel or reside outside the United States or Canada in the next two years? *(If "Yes," complete Foreign Travel and Residence Questionnaire.)* . . . . . ☐ Yes ☐ No
3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? *(If "Yes," complete Aviation Questionnaire.)* . . . . . ☐ Yes ☐ No
4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? *(If "Yes," to scuba diving, complete Scuba Diving Questionnaire. For all other "Yes," complete Avocations and Professional Sports Questionnaire.)* . . . . . ☐ Yes ☐ No
5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes or dune buggies? *(If "Yes," complete Motor Sports Questionnaire.)* . . . . . ☐ Yes ☐ No

G. PROPOSED INSURED PERSONAL HISTORY *(Continued)*

6. Except for traffic violations, have you been convicted in a criminal proceeding or are you the subject of a pending criminal proceeding? ☐ Yes ☐ No
7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? . . . . . ☐ Yes ☐ No

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

Question	Explanation

H. PAYMENT INFORMATION

1. Initial Payment: ☐ Check with Application[1] ☐ Cash on Delivery ☐ Credit Card[1, 2] ☐ EFT[1, 2]

2. Payment Amount $ _____

3. Frequency of Subsequent Payments: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly[3]

☐ Military Allotment[4] *(Active or retired military members must complete the Military Allotment form and return it to the military finance department.)*

☐ Civil Service Allotment[4] *(The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)*

[1] *No temporary coverage shall take effect unless a valid Temporary Insurance Receipt is received and all of the conditions stated therein are satisfied.*
[2] *To pay the initial premium by credit card or EFT, complete Appendix F.*
[3] *For your convenience, monthly payments are available with electronic funds transfer; to draft monthly payments, complete Section B of Appendix F.*
[4] *Two full monthly premium payments are required before the policy becomes active.*

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

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

☐ I elect the Automatic Premium Loan (APL) Option.

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

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

Plan Provider Name _____

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

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

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

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

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

4. Address _____ City _____ State _____ ZIP _____

L. POLICY BACKDATING INFORMATION

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

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

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

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

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

M. FINANCIAL DETAILS *(Questions 2-6 should be completed by the Proposed Insured and Proposed Owner, if different.)*

1. Do you (the Proposed Owner) believe this proposed life insurance policy will meet your future financial needs and objectives? . . . ☐ Yes ☐ No

Annual figures should be from the last tax year. Total figures should be as of the application date.	Proposed Insured	Proposed Owner
2. Annual Earned Income *(salary, commissions, bonuses, etc.)*	$	$
3. Annual Interest and Other Income *(interest, dividends, pension & rental income, annuity and social security payments, etc.)*	$	$
4. Total Assets *(cash, securities, real estate, cars & personal property, 401K Plans / Pensions Funds, business ownership interests, etc.)*	$	$
5. Total Liabilities *(outstanding debts: mortgages and loans)*	$	$
6. Total Net Worth *(Total Assets minus Total Liabilities)*	$	$

7. Has the Proposed Insured / Proposed Owner or any company owned by either ever declared bankruptcy? *(If "Yes," complete below.)* . . ☐ Yes ☐ No
   a. Bankruptcy filed by _____ b. Chapter Type _____ c. Date Discharged _____

For personal insurance, complete questions 8-11.

8. How much life insurance is in force on the Proposed Insured's spouse / domestic partner that is payable to the Proposed Insured or other dependents? $_____
9. What is the annual income of the Proposed Insured's spouse or domestic partner? $ _____
10. If this application is for a juvenile, indicate the amount of life insurance in force on each parent or sibling.
    Father $ _____ Mother $ _____ Sibling $ _____
11. Purpose of Personal Insurance: ☐ Estate Liquidity ☐ Family Protection ☐ Tax Planning ☐ Retirement Planning ☐ Cash Accumulation ☐ Other _____

For business insurance, complete questions 12-15.

12. Purpose of Business Insurance: ☐ Buy/Sell ☐ Key Person ☐ Other _____
13. Total Business Assets $ _____ Total Business Liabilities $ _____ Total Business Net Worth $ _____
14. Business Net Profit After Taxes for Past Two Years: Last Year $ _____ Previous Year $ _____

15. Business Owner Name *(Executives excluding Proposed Insured)*	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?
		$	%	☐ Yes ☐ No
		$	%	☐ Yes ☐ No

N. IN FORCE / REPLACEMENT INFORMATION *(This section applies to the Owner and the Proposed Insured. Please read each question and if the answer is "Yes" for either the Owner or Proposed Insured, then respond "Yes." If the answer is "No" for both the Owner and Proposed Insured, then respond "No." If a replacement is occurring, the owner of the existing policy is required to terminate the existing policy with a separate written request to the insurance provider.)*

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

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

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . . . ☐ Yes ☐ No
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . ☐ Yes ☐ No

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

Insured Name	Insurance Company	Policy Number	Amount
			$
			$
			$

O. MEDICAL TRANSFER STATEMENT *(Completed by the proposed insured when submitting medical examinations from another insurance company.)*

1. Insurance Company Name _____ 2. Examination Date _____

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

_____

P. [ING'S] POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI) *(This section applies to the Proposed Owner and the Proposed Insured, if different.)*

The Company, along with other [ING Life Companies] does not issue policies designed to obtain life insurance for the benefit of a third party (a "stranger") that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company shall seek to void any STOLI policy issued.

The Company considers the following arrangements to be fraudulent and does not sell life insurance in the following circumstances:

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

The activities described above are considered "prohibited conduct".

To the best of your knowledge and belief, have you engaged in any Prohibited Conduct described in this Section P in connection with this application for insurance? ☐ Yes ☐ No

Q. ACKNOWLEDGEMENTS, CERTIFICATIONS, AUTHORIZATIONS AND REPRESENTATIONS

Acknowledgements and Agreement: By signing this application, I acknowledge and agree that:

1. **Application:** I have read this application and I agree with the statements in this application.
2. **Rescission for False Statements:** The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information.
3. **Information Limited to Application.** The application will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein.
4. **Company's Liability for Insurance Coverage.** Unless otherwise stated in a valid Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, there is no material change in the health of the Proposed Insured between the time of application and the time of delivery of the policy, and the first premium is received by the Company while the Proposed Insured is alive.
5. **Temporary Insurance.** If I have paid premium by check with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application.
6. **No Waiver by Producer.** The producer does not have the authority to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements.
7. **Application Changes.** No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing.
8. **Delivery Requirements.** If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force.
9. **Signature.** By signing this application, I am applying for life insurance coverage issued by the Company.
10. **Receipt of Disclosure and Forms.** I received the following disclosures and notices: Accelerated Benefit Rider Disclosure, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices.
11. **Governing Law.** The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.
12. **Jurisdiction.** Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

Q. ACKNOWLEDGEMENTS, CERTIFICATIONS, AUTHORIZATIONS AND REPRESENTATIONS *(Continued)*

Certification. By signing this application, I certify, under penalty of perjury, that my Social Security Number / Tax Identification Number is shown and is correct and that I am not subject to back-up withholding.

Authorizations: By signing this application, I make the following authorizations:

1. **Collection of Medical Record Information or Investigative Reports.** I authorize the Company and other insurance companies affiliated with the Company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application.
2. **Release of Records.** I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original.
3. **Investigative Consumer Reports.** If an investigative consumer report is prepared, I request to be interviewed. ☐ Yes

   Daytime phone number: (_____)_____.

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

Representations. By signing this application, I represent that:

1. All questions have been truthfully answered to the best of my knowledge and belief.
2. The policy is not STOLI and I have not engaged in any prohibited conduct as described in Section P above.
3. The Owner has an insurable interest in the life of the Proposed Insured.
4. I agree to inform the Company of any known material change in health of the Proposed Insured prior to delivery of the Policy.

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

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Insured Signature *(If age 15 or older)* _____ Date _____

Proposed Owner / Trustee Signature[1] *(If other than the Proposed Insured)* _____ Date _____

Proposed Owner / Trustee Name *(Please print.)* _____

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

[1] *All owners' signatures are required.*

R. AGENT'S REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION

I represent that the policy applied for is not STOLI as described in Section P, "[ING's]Policy on Stranger- Owned or Stranger-Originated Life Insurance (STOLI)." I represent that I am not aware that the applicant is applying for insurance coverage for a stranger as part of a STOLI arrangement and neither I nor the applicant are aware of any information that would notify the Company of the policy's use as STOLI. Neither I nor the applicant have provided any information to the Company contrary to the representations I have made and the applicant has made concerning the policy's use as STOLI. My signature also certifies that except as provided in the answers to the in force replacement questions, the proposed insured(s) / owner(s) do not own any existing life insurance or annuity contracts and no other replacement of insurance or annuity is involved in this transaction. I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

To the best of my knowledge and belief, all answers provided by the Owner and Proposed Insured in the above application are true, correct and complete.

Writing Agent Signature _____ Date _____

Writing Agent Name *(Please print.)* _____ Writing Agent Number _____

ALL COMPLETED MATERIALS MUST BE SENT TO THE[ING CUSTOMER SERVICE CENTER].