INDIVIDUAL TERM LIFE INSURANCE APPLICATION

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401
("the Company")

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

A. PRODUCT INFORMATION

1. Product Name _____ 2. Issue Type: ☐ Fully Underwritten ☐ Simplified Issue

3. Initial Term Period: ☐ 15 Year ☐ 20 Year ☐ 30 Year 4. Stated Death Benefit *(Not including riders)* $ _____

5. Does the Proposed Insured elect the Extended Premium Guarantee? *(Automatically provided with the Premium Endowment Rider)* ☐ Yes ☐ No

When selected, the Extended Premium Guarantee period will last for the duration of the initial term period. If not selected, the Fully Underwritten premium guarantee period will last for 10 years and the Simplified Issue premium guarantee period will last for five years on the 15 and 20 year initial term periods and 15 years on the 30 year initial term period.

B. RIDER INFORMATION *(Not all riders are approved in all states.)*

OPTIONAL RIDER BENEFITS — Benefit Amount

- ☐ Accidental Death Benefit Rider $ _____
  (You may purchase up to 50% of the Stated Death Benefit. Only available with Simplified Issue policies.)
- ☐ Accident Only Disability Income Rider $ _____
- ☐ Children's Insurance Rider
  (Complete Children's Insurance Rider Application.)
- ☐ Critical Illness Rider $ _____
- ☐ Premium Endowment Rider *(Not available with the 15 year initial term period. The Extended Premium Guarantee is automatically provided with this rider.)*
- ☐ Waiver of Premium Rider - Disability
- ☐ Other_____ $ _____

AUTOMATIC RIDER BENEFITS

- Accelerated Benefit Rider
  (Only available with Fully Underwritten policies.)
- Common Carrier Accidental Death Benefit Rider
  (Only available with Simplified Issue policies.)
- Waiver of Premium for Unemployment
- Other _____
  (Other riders may be automatically available in your state.)

C. PROPOSED INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____ Suffix _____

2. Birth Date _____ 3. Birth State and Country _____ 4. Gender: ☐ Male ☐ Female

5. SSN/Government Issued ID Number _____ 6. Driver's License Number _____ State _____

7. Residence Address _____ City _____ State _____ ZIP _____

8. Daytime Phone (_____)_____ 9. Evening Phone (_____)_____ 10. E-mail _____

11. Are you a U.S. citizen? ☐ Yes ☐ No If "No," Country of Citizenship _____ Visa Status _____

12. Are you currently employed? ☐ Yes ☐ No *(If "No," skip to question 16.)*

13. Occupation *(Include duties)* _____

14. Employer _____

15. Employer Address _____ City _____ State _____ ZIP _____

16. Annual Earned Income $ _____ Annual Other Income $ _____ Total Net Worth $ _____

D. OWNER (PAYOR) *(Complete this section only if the Owner is different than the Proposed Insured.)*

1. First Name _____ MI _____ Last Name _____

2. Birth Date _____ 3. SSN/TIN _____ 4. E-mail _____

5. Relation to Proposed Insured _____ 6. Daytime Phone (_____)_____

7. Residence Address _____ City _____ State _____ ZIP _____

E. 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.)*

Name *(First, MI, Last)*	Birth Date	SSN	Phone	Relationship to Proposed Insured	%	Beneficiary Type
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent
						☐ Primary ☐ Contingent

F. PAYMENT INFORMATION

1. Initial Payment: ☐ Credit Card ☐ Electronic Funds Transfer ☐ Check ☐ On Delivery of Policy 2. Amount $ _____

The credit card option is only available for the initial payment. If you choose to pay by credit card or electronic funds transfer, you must complete the attached Credit/Debit Card Payment Authorization and Electronic Funds Transfer (EFT) form (Appendix E). Any payment by check with application must have the Temporary Insurance Receipt completed (Appendix A).

3. Frequency of Subsequent Payments: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly *(Available with Electronic Funds Transfer only.)*

4. You may choose to backdate your policy up to a maximum of six months (depending on individual state requirements) to "save age," which means that we will calculate the premium based on a younger age. Backdating a policy may save you money by lowering your premium. If you choose to backdate your policy, you must 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 you 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. Please consult your producer 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 ☐ No Requested Backdating Date _____

G. 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 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
			$
			$
			$

H. PERSONAL HISTORY *(Questions 1 - 7 must be completed for the Proposed Insured.)*

1. Have you ever declared bankruptcy? *(If "Yes," provide details in Item 8 below, including the discharge date.)* . . . . . ☐ Yes ☐ No
2. Are you, or have you entered into a written agreement to become a member of the armed forces, including the Reserves? . . . . ☐ Yes ☐ No
3. In the next two years, do you intend to travel or reside outside the United States or Canada (other than a vacation to Western Europe or the Caribbean lasting two weeks or fewer)? . . . . . ☐ Yes ☐ No
4. Do you now or in the next two years plan to fly a plane (other than as a commercial pilot), race motor boats, automobiles or motorcycles, or participate in sky-diving, soaring, hang-gliding, ballooning, mountain climbing, rodeo, scuba diving, or competitive skiing? . . . . . ☐ Yes ☐ No
5. Except for traffic violations, have you been the subject of or been convicted in a criminal proceeding? . . . . . ☐ Yes ☐ No
6. In the last five years, have you had any motor vehicle accidents in which you were found to be at fault, any alcohol or drug related convictions, or other moving violations while operating a motor vehicle? . . . . . ☐ Yes ☐ No
7. In the last five years, have you used tobacco or nicotine products of any type? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . . . ☐ Yes ☐ No

If "Yes," indicate type _____ Amount and Frequency _____ Month/Year Last Used _____

8. For any "Yes" answer to questions 1 - 6, please provide details in the chart below.

Question	Details

I. MEDICAL DECLARATIONS *(Provide data on Proposed Insured.)*

1. Proposed Insured Height _____ Weight _____ Loss or gain in pounds during the last year _____
2. Personal Physician Name _____ 3. Physician Phone (_____)_____
4. Physician Address _____ City _____ State _____ ZIP _____
5. Date last seen by physician _____ 6. Reason for consultation _____
7. Results of consultation _____

_____

8. In the past 10 years, have you been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:
   a. Dizziness, seizures, convulsions, headaches, paralysis, a stroke, TIA, or a mental or nervous disorder, including anxiety or depression? . . . ☐ Yes ☐ No
   b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder? . . . . . ☐ Yes ☐ No
   c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or any other disorder of the heart or blood vessels? . ☐ Yes ☐ No
   d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or any other disorder of the stomach, intestine, liver, pancreas, or gall bladder? . . . . ☐ Yes ☐ No
   e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or any other disorder of the kidney, bladder, breasts, prostate, or reproductive organs? . . . . . ☐ Yes ☐ No
   f. Diabetes, thyroid, or any other endocrine disorder? . . . . . ☐ Yes ☐ No
   g. Disorder of the skin or lymph glands, arthritis, or any disorder of the muscles, joints, or bones? . . . . . ☐ Yes ☐ No
   h. Anemia or any other disorder of the blood? . . . . . ☐ Yes ☐ No
   i. A positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system? . . . ☐ Yes ☐ No
9. In the past 5 years, have you:
   a. Had any operations or been advised by a health care provider to have operation(s), treatments, or diagnostic tests that have not yet been performed (excluding HIV testing)? . . . . . ☐ Yes ☐ No
   b. Had an electrocardiogram, x-ray, or other diagnostic test (excluding HIV testing)? . . . . . ☐ Yes ☐ No
   c. Been confined for observation, care, or treatment in a hospital or other health care facility? . . . . . ☐ Yes ☐ No
   d. Been treated, examined or advised by a member of the medical profession not already identified, for any reason including routine physical examination? . . . . . ☐ Yes ☐ No
10. Have you:
   a. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? . . . . . ☐ Yes ☐ No
   b. Ever used or are you currently using Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? . . . . . ☐ Yes ☐ No
   c. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer? . . . . . ☐ Yes ☐ No
11. Are you presently taking any medication(s), including non-prescription/over-the-counter medication or supplements? . . . . . ☐ Yes ☐ No

12. Family History

	Age if Living	Age at Death	Cause of Death
Father			
Mother			

I. MEDICAL DECLARATIONS *(Continued)*

13. For any "Yes" answer to questions 8 - 10 on the previous page, please record information in chart below. If you need additional space, please attach a separate piece of paper to the application.

Question	Condition/Diagnosis	Dates/Duration of Condition/Treatment	Physician Name	Physician Address

J. PRODUCER INFORMATION *(For questions about this application or requirements, contact the underwriting department.)*

Each licensed producer will share equally unless otherwise indicated.

Producer Name *(Please print.)*	Producer ID Number	% Split	General Agent Name	General Agent Number

Writing Producer Address _____ City _____ State _____ ZIP _____

K. PRODUCER CERTIFICATION

1. How long have you known the Proposed Insured? _____ 2. Are you related? ☐ Yes ☐ No How? _____

3. Have you scheduled an exam? ☐ Yes ☐ No If "Yes," provide the paramed company name. _____

By my signature in Section M, I certify that:

- To the best of my knowledge and belief, the answers provided in Section G, In Force/Replacement Information, are true and correct.
- Only company-approved sales materials were used and copies of all sales material were left with the applicant no later than the time of application. (Electronically presented sales materials must be provided to the Owner no later than at the time of the policy delivery.) The Company requires that all replacement sales are made in accordance with its corporate replacement policy. If this particular sale is NOT in accordance with the Company's corporate replacement policy, please check here ☐ and attach an explanation.
- All of the Appendices and Disclosures have been delivered to the client.

Use this area for special instructions.

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

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

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

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

The activities described above are considered "prohibited conduct."

M. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION

Representations and Acknowledgements. By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and represent that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. Unless otherwise stated in a Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, 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. If I have paid premium with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

By my signature on Page 6 of this application, I affirmatively warrant and represent that I have not engaged in any prohibited conduct described in Section L above in connection with this application for insurance.

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

I acknowledge receipt of the following disclosures and notices: Accelerated Benefit Rider and Critical Illness Disclosures, Notice Regarding Consumer Reports, Notice Regarding Collection of Information and Information Practices and Notice Regarding MIB, Inc. 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.

By my signature on Page 6 of this application, I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:

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

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

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.

Authorization for the Release of Health-Related Information. *(This authorization is HIPAA compliant.)* I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me and any minor children to be insured to the Company and its producers, employees, and representatives. 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 acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and 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. This protected health information is to be disclosed under this authorization so that the Company 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 Company.

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 Company, Attention: Privacy Official, PO Box 5053, Minot, ND, 58702-5053. 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 Company 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.

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 Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that the authorizations provided herein will be valid for 24 months from the date of signature on this application.

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.

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

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

Signed At *(City/State)* _____ Date _____

➥ Proposed Insured Signature _____

Print Owner Name *(If other than the Proposed Insured)* _____

➥ Owner Signature *(If other than the Proposed Insured)* _____ Date _____

By signing below, I acknowledge receipt and acceptance of the terms of the current ING Life Companies General Agent or Producer Agreement ("Agreement"), whichever is applicable, including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker-Dealer and do not hold an Agreement such that this language is inapplicable. I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

I have completed Section J, "Producer Information," and Section K, "Producer Certification," and by my signature below, I affirm that the information contained therein is true and complete to the best of my knowledge.

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

➥ Writing Producer Signature _____ Date _____

Writing Producer Name *(Please print.)* _____ E-mail _____

SPLIT SALES ONLY:

Producer Name *(Please print.)* _____ Producer Name *(Please print.)* _____