




*You never know what can happen on your shift.  
Is your family financially secure?*



Benefits Division

Group Life Insurance and  
Accidental Death Insurance



The California State Firefighters' Employee Welfare Benefits Corporation recommends all CSFA members take advantage of this unique offer of Low Cost, High Benefit, Group Term Life Insurance.

**Protecting your family's financial security is YOUR responsibility. APPLY TODAY! It's never been easier.**

With your demanding career, busy family life, and many pressing day-to-day issues, it's easy for Life Insurance Planning to get left on the "To Do List" for months.

So if you haven't taken a close look at your family's need for additional protection, we urge you to do it today.

**Now is the time to apply for the CSFEWBC Sponsored 10-Year Simplified Group Term Life Insurance Plan at affordable group rates. For a limited time you can apply for the following amounts based on your age:**

Under 40	\$250,000
40-49	\$150,000
50-59	\$100,000
60-65	\$50,000

So take a quick look at the rates in the attached application. The rates are designed to remain level for 10 years, based on your current age.\* This Simplified Issue Group Term Life Plan is only available for a limited time. Consider if any of the following has occurred over recent months/years, which can indicate your need for additional Life Insurance protection:

- Have you increased the size of your family?



**Up to \$100,000.00 in life insurance protection**

- Did you purchase a larger house or increase your mortgage?
- Are your kids nearing college age?
- Get married or divorced recently?
- Responsible for assisting with your parents' well-being?
- Getting ready for retirement planning?
- Received a promotion or raise recently?

All of these events mean more financial responsibility for you and your family, and the need for more protection. Simply put, more Life Insurance. The CSFEWBC - Sponsored Simplified Issue Group Term Life Plan works as an excellent supplement protection to any existing Life Insurance you may already have through your department, or through another insurance company.

### **DON'T WAIT - APPLY NOW!**

**This offer expires October 31, 2015**

Visit [www.csfainsurance.org](http://www.csfainsurance.org)

Applying is simple. Just complete the online application. Upon your approval, you'll receive a Certificate of Insurance by email for your review. If you're not completely satisfied, just return your Certificate without further obligation within 30 days.

Why not get this issue off your "To Do List"? Apply today, for affordable term coverage for your family's financial future.

Now it's easier than ever to add additional amounts of Term Life Insurance coverage.



**Exclusive to CSFA Members!**





### **Up to \$250,000.00 in protection for 10 years**

The California State Firefighters' Employee Welfare Benefits Corporation California State Firefighters' Employee Welfare Benefits Corporation-Sponsored Group Term Life Insurance Plan is designed to provide an affordable update to your family's financial security. You must be a member of CSFA, age 65 or under and actively working at least 20 hours per week to apply for this pure term coverage. Nothing will inflate the cost, because it's a 10-Year Level Plan, your premium is designed to remain level based on your age when you apply.\*

**Your initial premium is designed to not increase for the first 10 years\*- Regardless of changes in your health**

### **Need Dependent Family Coverage?**

You can also elect Dependent Family Coverage, providing \$10,000 Life Insurance Protection for your spouse or domestic partner, and all eligible children (*eligible child is defined as your unmarried child from birth to age 21 or to 25 if a full-time student*). This protection costs only \$1.80 monthly. This is all you pay per month regardless of the number of children you have.

### **Pay No Premiums if you become Disabled**

Should you become disabled, as defined in the Insurance Certificate, before age 60, you may keep your coverage, subject to policy provisions, without paying premiums.

### **Accelerated Life Benefit Protection, Up to \$100,000.00**

If you are diagnosed with a medical condition with a life expectancy of 6 months or less, you may apply for an accelerated



**Up to \$100,000.00 in AD&D insurance protection**

payment of up to 50% of your benefit amount, up to \$100,000. This payment could help you and your loved ones with financial burdens during this difficult time. Receipt of accelerated benefit payments may be taxable. Assistance should be sought from a personal tax advisor.

### **Level Term Protection for 10 years**

At the end of the 10-year period, evidence of insurability is required to enter another Level Term period (*subject to the maximum age to begin a Level Term period*).

If evidence of insurability is not provided or not approved by ReliaStar Life, rates will be based on the 5 year age brackets (rate increases as you enter a new 5-year age bracket) for your current age... Still affordable.

### **Coverage Effective Date**

The coverage becomes effective as soon as your application is approved and the first premium has been paid.

### **Level Coverage Continuation**

Coverage will not reduce during your Level Term period. For members who are under age 60 at the end of a Level Term period, coverage will not reduce until age 60.

At that time, coverage will reduce as follows:

to 65% at age 60; to 45% of initial coverage amount at age 65; to 30% of initial coverage amount at age 70; to 15% of initial coverage amount at age 75; to 10% of initial coverage amount at age 80. If your Level Term period ends when you are age 60 or above, your coverage will reduce to the level it would per the above reduction schedule for the age you are at the end of the Level Term period. Coverage will continue as long as you are a member of CSFA, the group policy remains in force, and premiums are paid when due.



**Protect Your Family!**

## Accidental Death Insurance

These plans offer optional accidental death coverage to help with the added expenses that often occur with a sudden unexpected accident. If you elect the Accidental Death insurance option, the plan will pay your beneficiary double the amount of your voluntary Life Insurance should you die in a covered accident. The cost of adding the Accidental Death coverage is only .04\* cents per month per \$1,000 dollars of coverage (\$250,000 maximum benefit available).

## Exclusions

The only exclusion under the Group Term Life policy is suicide within the first 2 years of coverage. The Accidental Death Benefits are subject to additional exclusions.

**Satisfaction is Guaranteed**  
**Don't wait apply - TODAY!**

Visit [www.csfainsurance.org](http://www.csfainsurance.org) for enrollment.

## Why wait?

Apply today for affordable coverage and get it off your "To Do List".

If you are interested in additional levels of coverage (up to \$1 million dollars) call **800.827.4695**.



**Peace of Mind**

*\*The initial premium will not change for the first 10 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice. To keep coverage in force, premiums are payable up to the date of policy or coverage termination.*

*Your insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. ReliaStar Life Insurance Company is rated A (excellent) by A.M. Best company. This is the third highest of 15 ratings. A.M. Best Company assigns ratings from A++ to F based on a company's financial strength and ability to meet obligations to contract holders.*

*This brochure is for summary purposes only.  
For a complete description of benefits and limitations,  
please read your Certificate of Insurance.*

*Policy Form LP00GP*

**Financial Security**



# What are you waiting for?



*Plans arranged and administered by:*

 **Myers-Stevens & Toohey & Co., Inc.**  
26101 Marguerite Parkway  
Mission Viejo, CA 92692  
800-827-4695 or fax 949-348-2630

9075 Foothills Blvd. #4  
Roseville, CA 95747  
800-827-4695 or fax 916-772-0697

CA License No. 0425942



## Apply Today! Call 800.827.4695





**California State Firefighters' Employee  
Welfare Benefits Corporation**

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**Simple, Affordable & SAFE!**

**Limited Time Simplified Issue Offer**

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**Group Term Life Insurance  
Application  
(10-Year Level Term Rate)**

C2

# Group Term Life Application for 10-Year Level Term Rate

Reference to Spouse includes Spouse or Domestic Partner

Please use this application to apply for Simplified Issue Insurance coverage during the specified enrollment period. If approved, your life coverage under this group policy will enter a 10-year level term rate period.

Please print clearly (black ink): Fax, Mail or Scan and e-Mail to:

**Myers-Stevens & Toohey Co.** | 26101 Marguerite Parkway | Mission Viejo | CA 92692  
phone 800.827.4695 | fax 949.348.2630 | CSFA@myers-stevens.com | license #0425842

## CSFEWBC (Policy 67180-1)

### Tell us about yourself:

Department Name \_\_\_\_\_

Are you a member of CSFA? ☐ Yes ☐ No

Your Name \_\_\_\_\_  
(last, first, middle)

☐ Female ☐ Male

Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

E-mail \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

1. Amount of coverage applied for during this enrollment period:

☐ Under Age 40 - \$250,000 ☐ Age 40 – 49 - \$150,000 ☐ Age 50 – 59 - \$100,000  
☐ Age 60 – 65 - \$50,000

2. Matching Accidental Death Benefit (\$200,000 Maximum Benefit): Member ☐ Yes ☐ No

3. Check box to purchase: ☐ \$10,000 Dependent Family Insurance  
(check only if applying for dependent family coverage for the first time under this Group Policy)

4. Have you used tobacco products of any kind in the last 12 months? ☐ Yes ☐ No

5. Are you currently working at least 24 hours per week at your regular occupation and place of business? ☐ Yes ☐ No If no, please explain: \_\_\_\_\_

6. Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

## Beneficiary Information

List one or more beneficiaries below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent coverage will be the certificate holder.

Name	Address	Relationship	Percent

### Provide Us with this Health Information:

1. During the past 10 years have you consulted a doctor or health practitioner, taken medication or had treatment for any of the following:

- ☐ Yes ☐ No    A. Cancer, tumors, stroke, connective tissue disease, diabetes, rheumatoid arthritis, Acquired Immune Deficiency Syndrome (AIDS), severe injury, organ transplant
- ☐ Yes ☐ No    B. Disease or disorder of the heart, brain, liver, kidney, blood or lung (excluding asthma requiring oral steroid use)

2. In the past 5 years have you ever been diagnosed with or been treated for:

- ☐ Yes ☐ No    A. Other disease or disorder of the immune, neurological, digestive, urinary, circulatory (excluding controlled high blood pressure) or respiratory system
- ☐ Yes ☐ No    B. Major or manic depression, psychosis, suicide attempt, use of alcohol, drugs or narcotics?

3. In the past 5 years, have you had surgery, been confined or treated in a hospital or similar facility due to serious illness, or been advised to receive medical attention for any symptom(s) or condition?

- ☐ Yes ☐ No

*If you answered yes to any of the questions above, please give full details below.  
Attach an additional sheet if needed*

Condition/Illness/Treatments

Date(s) of Treatment

Physician Name/Mailing Address


**Read this information carefully:**

1. To the best of my knowledge and belief, the information I've provided is complete and correct.
2. 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.
3. I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

**Authorization & Acknowledgment – Please read & sign below:**

For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, 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 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 to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form.

I specifically consent to the 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.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life it's 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.

As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who knowingly and with intent to defraud, submits an application or files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

GTLEVELSI06-CA

ReliaStar Life Insurance Company | Box 20 | Minneapolis, MN 55440

The administrative information below is not part of the insurance application. Please complete and return. Do not detach from the application.

As a member in good standing of the California State Firefighters Association, I hereby request to participate in the Life Insurance Plan sponsored by the California State Firefighters' Employee Welfare Benefits Corporation and underwritten by ReliaStar Life Insurance Company. I agree that premiums for this insurance shall be paid by payroll deduction, if available; otherwise, as billed by Myers-Stevens & Toohey & Co., Inc. If payroll deduction is not available, I prefer to be billed directly and pay my premiums: (check appropriate box)

☐ Quarterly

☐ Semi-Annually

☐ Annually

Upon completion, Fax, Mail or Scan and e-Mail to:

**Myers-Stevens & Toohey Co.** | 26101 Marguerite Parkway | Mission Viejo | CA 92692  
phone 800.827.4695 | fax 949.348.2630 | CSFA@myers-stevens.com

# Monthly Premium Rates for 10-Year Group Level Term Insurance\*

## Monthly premium for \$250,000 in coverage

Issue Age	Non-Tobacco User	Tobacco User
18-26	11.50	24.34
27	11.50	24.83
28	11.50	25.64
29	11.50	26.72
30	11.50	29.43
31	11.50	31.04
32	11.50	32.96
33	11.50	35.15
34	11.50	37.58
35	11.50	40.31
36	11.75	43.26
37	12.00	46.48
38	12.75	50.05
39	13.25	53.93

## Monthly premium for \$150,000 in coverage

Issue Age	Non-Tobacco User	Tobacco User
40	8.70	34.91
41	9.45	37.73
42	10.50	40.77
43	11.70	44.00
44	12.90	47.33
45	14.25	50.67
46	15.60	54.02
47	16.95	57.48
48	18.30	61.20
49	19.95	65.36

## Monthly premium for \$100,000 in coverage

Issue Age	Non-Tobacco User	Tobacco User
50	14.70	46.64
51	16.20	49.99
52	18.00	53.58
53	19.90	57.48
54	22.20	61.75
55	24.50	66.22
56	26.80	70.69
57	29.30	75.41
58	32.10	80.94
59	35.30	87.85

## Monthly premium for \$50,000 in coverage

Issue Age	Non-Tobacco User	Tobacco User
60	21.00	54.45
61	22.70	59.55
62	24.25	65.30
63	26.20	71.95
64	28.50	79.70
65	32.05	88.70

**MATCHING ACCIDENTAL DEATH COVERAGE  
AT \$.04 PER MONTH PER \$1,000 IN  
COVERAGE.**

\*The initial premium will not change for the first 10 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice. To keep coverage in force, premiums are payable up to the date of policy or coverage termination.  
Rates shown above are as of August, 2015.

Rates are provided for your information **and** are not part of the life insurance application.

ReliaStar Life Insurance Company | Box 20 | Minneapolis, MN 55440 | Policy Form LP00GP

## **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.

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**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.

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