ILLINOIS STATE BAR ASSOCIATION

Senior Group Term Life Application

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ***ISBA Group Insurance Program, P.O. Box 10374, Des Moines, IA 50306-8812, or call 1-800-503-9230, or email customerservice.service@mercer.com.***

Illinois State Bar Association **Policy No. 67941-1**

1. TELL US ABOUT YOURSELF

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

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

Spouse/Domestic Partner's Information ***(complete this section only if applying for Spouse/Domestic Partner coverage on this application):***

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

2. SELECT YOUR COVERAGE

Member Amount (Age 50-74): ❑ $50,000 ❑ $25,000 ❑ $10,000

Spouse/Domestic Partner Amount (Age 45-74): ❑ $50,000 ❑ $25,000 ❑ $10,000

	Member	**Spouse/DP**
a.) In the past 2 years, have you been disabled due to sickness or injury?	❑ Yes ❑ No	❑ Yes ❑ No
b.) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	❑ Yes ❑ No	❑ Yes ❑ No

If yes, please explain:_____

3. PROVIDE YOUR HEALTH INFORMATION

Member: **Height_____ft. _____in. Weight_____lbs.** Spouse/DP: **Height_____ft. _____in. Weight_____lbs.**

	Member	Spouse/DP
1. Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke, cancer/tumor, diabetes, seizures, AIDS (Acquired Immunodeficiency Syndrome) or a positive HIV (Human Immunodeficiency Virus) test?	❑ Yes ❑ No	❑ Yes ❑ No
b. memory loss, Alzheimer's disease, dementia, depression or any other mental/nervous disorder?	❑ Yes ❑ No	❑ Yes ❑ No
c. disease or disorder of the heart, lungs, liver or kidneys?	❑ Yes ❑ No	❑ Yes ❑ No
d. disease or disorder of the blood, or neurological, immune, digestive or intestinal system?	❑ Yes ❑ No	❑ Yes ❑ No
2. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the past 2 years, have you been hospitalized or admitted to a medical care facility (or been advised by a member of the medical profession to do so), or had medical tests, procedures or treatments recommended by a member of the medical profession that have not yet been performed?	❑ Yes ❑ No	❑ Yes ❑ No
4. Do you receive in-home medical care or need personal or mechanical assistance in walking, bathing or dressing?	❑ Yes ❑ No	❑ Yes ❑ No

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

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

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Attach additional sheets if necessary.

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

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

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

Beneficiary for Spouse/Domestic Partner Coverage ***(complete this section only if applying for Spouse/Domestic Partner coverage on this application)***

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

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

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

***(Choose only one. Option selected is applicable to all coverages approved through this application)*:**

❑ **Option 1:** **AUTOMATIC CHECK WITHDRAWAL REQUEST:** ❑ Monthly ❑ Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ____ ____ ____ ____ ____ ____ ____ ____ ____ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

❑ **Option 2:** **DIRECT BILL:** ❑ Quarterly ❑ Semi-Annual ❑ Annual
Billing dates will begin after coverage is approved and initial premium has been received.

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

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

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

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

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

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

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

Member's Signature (always required)	Date	Spouse/Domestic Partner's Signature (if applying)	Date

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

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

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Domestic Partnership Declaration

Name of Applicant _____

Name of Domestic Partner _____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.

2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).

3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):

- ❑ Common ownership of a motor vehicle.
- ❑ Joint bank or credit accounts.
- ❑ Assignment of durable power of attorney in favor of one another.
- ❑ Common ownership of real estate or common leasehold interest in property.
- ❑ Joint ownership or holding of stocks, bonds or other investments.
- ❑ Execution of will naming each other as executor and/or beneficiary.
- ❑ Designation as beneficiary under the other's retirement or pension benefits account.

4. That the undersigned member and domestic partner (check one):

- ❑ have filed a domestic partner declaration with the (City/Council/Borough) of_____ and that such domestic partner declaration remains in effect (attach copy of declaration).
- ❑ do not reside in a jurisdiction that provides for the registration of domestic partnership declarations.

5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.

6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.

7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability that would prevent them from making this affidavit.

8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.

9. That the undersigned member and domestic partner are not related by blood in any degree that would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature_____ **Date**_____

Soc. Sec. No._____

Domestic Partner's Signature_____ **Date**_____

Soc. Sec. No._____

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Group Senior Term Life Insurance Plan

ILLINOIS STATE BAR ASSOCIATION

An affordable life insurance plan designed especially for members 50 and older.

More about the benefits of your Group Senior Term Life Insurance Plan …

FOR ISBA MEMBERS AND THEIR SPOUSE/DOMESTIC PARTNER

ELIGIBILITY

All members and their spouse/domestic partner in good standing residing in the United States between the ages of 50 and 74 (spouse's/domestic partner's between the ages of 45 and 74) are eligible to apply for coverage as long as they are able to perform the daily living activities of a person of like age and sex. Members and spouses/domestic partners can select a life insurance amount of $10,000 to $50,000 (in increments of $5,000).

You don't need a medical exam. Just answer a few questions to the satisfaction of the insurance carrier on the enclosed Application and we'll get the paper work going on as much as $50,000 in ISBA's Group Senior Term Life Insurance benefits.

PLAN FEATURES

No Medical Exams
You don't need a medical exam. You don't need to have your doctor send in your medical records. All it takes is satisfactorily answering to the insurer the questions on the enclosed Application and we'll get the paper work going on as much as $50,000 in ISBA's Group Senior Term Life Insurance benefits.

Satisfaction Guaranteed
You may return your Certificate of Insurance within 30 days if you are not completely satisfied with the coverage this Plan provides. Any premiums paid will be fully refunded provided no claims have been submitted or paid.

Convenient Payment Options
Automatic Monthly Check Withdrawal: Choose to have your premiums automatically deducted from your checking account on a monthly basis.

Direct Bill: Choose to have your premiums billed to you directly on a quarterly, semiannual or annual basis.

Beneficiary Selection
You may name anyone you wish as the beneficiary of this Plan, and you may change the beneficiary by contacting the Insurance Administrator in writing and advising them of the change.

You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

Effective Date
Your or your spouse's/domestic partner's insurance will become effective on the first day of the month on or after the later of the following dates:

- ReliaStar Life approves your or your spouse's/domestic partner's proof of good health;
- Your or your spouse's/domestic partner's premium is received;
- You or your spouse/domestic partner become eligible for insurance; or
- You or your spouse/domestic partner apply for insurance, if proof of good health is not required.

When Coverage Ends
Your insurance stops on the earliest of the following dates:

- The last day of the month during which you are no longer eligible for insurance under the Group Policy.
- The date the Group Policy stops.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.

Exclusions
The only exclusion is if you commit suicide, while sane or insane, within two years of the date your insurance or increase in insurance starts. The Accelerated Life Benefit is subject to additional exclusions.

Valuable Living Benefit Provision
"Accelerated Life Benefit"
The "Accelerated Life Benefit" option is available to help terminally ill insureds during a difficult, and often financially challenging, time. Under this provision, you may apply for a portion of your life insurance benefits, subject to certain policy restrictions and limitations. You can receive up to 50% of your insurance amount. This benefit is paid directly to you. You must have at least $5,000 in life insurance coverage in force to qualify. The amount of insurance payable after death will be reduced by the "Accelerated Life Benefit" payment. (Premium contributions will not be reduced.)

This money can be used to help cover high prescription drug costs … medical bills … outstanding debts … to help pay for experimental treatments … the cost of modifications to your home … or for a family vacation - the choice is yours.

To qualify, a terminally ill insured must be under age 75 at time of terminal diagnosis, provide ReliaStar Life with a doctor's statement that gives the diagnosis of the medical condition and states that the insured has a life expectancy of no more than 24 months. For additional details and limitations, please see the Certificate of Insurance.

Please note that receipt of Accelerated Life Benefits may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits, you should seek the advice of a qualified tax advisor.

Senior Group Term Life Semi-Annual Premium Rates per $5,000*

Rates guaranteed until March 31, 2019

Attained Age	Male	Female
45-49	$20.10	$13.80
50-54	$27.60	$15.60
55-59	$41.40	$23.70
60-64	$60.00	$39.60
65-69	$92.70	$66.90
70-74	$129.30	$101.40
75-79**	$100.38	$77.10
80-84**	$86.76	$62.46
85-89**	$266.58	$202.80
90+	$420.00	$331.50

*Rates are based on per $5,000 increment under age 75.

**Rates are based on per $2,500 increment for age 75-80, per $1,250 for age 80-85, and for $2,500 benefit at age 85+.

Member and Spouse /Domestic Partner coverage reduces to 50% at age 75, to 25% of original face value at age 80, to $2,500 at age 85. When your coverage reduces, it will never reduce below $2,500.

Note: Please contact the program administrator for rates for coverage amounts not listed in the rate chart above.
The program administrator can be reached at 1-800-503-9230.

About This Plan Information

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern.
The complete terms and conditions of coverage are contained in Group Policy 67941-1, which is issued to the Illinois State Bar Association. The group policy is sitused in the state of Illinois and is governed by its laws.
This is a paid endorsement. ISBA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.
Policy Form LP00GP

How to Apply

1. Complete, sign and date the Application. Be sure to indicate the coverage amount of your choice.
2. Do not send any money until ReliaStar Life Insurance Company has approved your Application and notifies you of the premium contribution due, based on the information you have provided.
3. Mail your completed Application to:
   ISBA Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

Administered by:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?
1-800-503-9230
http://www.isbainsuranceplans.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

Group Term Life Insurance Underwritten By:
ReliaStar Life Insurance Company
Minneapolis, MN

SLI1037P-50842