MINNESOTA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS

Senior Group Term Life Application

Please use this form to apply for **Simplified Issue** coverage. Please print clearly in dark ink and mail to ***MNCPA Group Insurance Program, P.O. Box 10374, Des Moines, IA 50306-8812, or call 1-800-732-8350, or email customerservice.service@mercer.com.***

Minnesota Society of Certified Public Accountants	**Policy No. 64269-0**

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

Name (Last, First, M.I.)		Name 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 Amount (Age 45-74): ❑ $50,000 ❑ $25,000 ❑ $10,000

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

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services performed at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization (at the bottom of this application) for a definition of "Emergency Medical Personnel."

	Member	Spouse
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				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				

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 Coverage ***(complete this section only if applying for Spouse 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, or my authorized representative, 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 12 months, whichever is less. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

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

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 penalties, and denial of insurance benefits.

Member's Signature (always required)	Date	Spouse'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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Group Senior Term Life Insurance Plan

MINNESOTA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS

FOR MINNESOTA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS MEMBERS

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

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

ELIGIBILITY

All members in good standing residing in the United States between the ages of 50 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. A member's spouse/domestic partner residing in the United States between the ages of 45 and 74 may also 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).

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 to get the paperwork going is your satisfactory answers to the insurer to the questions on the enclosed Application. Then the insurer can get to work on as much as $50,000 in MNCPA Group Senior Term Life Insurance Benefits.

Satisfaction Guaranteed
You may return your Certificate of Insurance within 30 days of receipt 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 under the group policy during the initial 30-day period.

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 insurance, 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 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 the insured's 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 provide ReliaStar Life with a doctor's statement that gives the diagnosis of your medical condition and states that you have a life expectancy of no more than six months. For additional details and limitations, please see the Certificate of Insurance.

Receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.

MNCPA GROUP SENIOR TERM LIFE INSURANCE PLAN
MONTHLY GROUP RATES

ATTAINED AGE - MEMBER & SPOUSE/DOMESTIC PARTNER	$10,000.00		$25,000.00		$50,000.00	
	Male	Female	Male	Female	Male	Female
45-49*	$6.70	$4.60	$16.75	$11.50	$33.50	$23.00
50-54	$9.22	$5.18	$23.05	$12.96	$46.10	$25.91
55-59	$13.78	$7.86	$34.46	$19.66	$68.91	$39.32
60-64	$20.00	$13.20	$50.00	$33.00	$100.00	$66.00
65-69	$30.93	$22.35	$77.32	$55.87	$154.64	$111.73
70-74	$43.14	$33.82	$107.84	$84.55	$215.68	$169.11

Rates shown are guaranteed until January 31, 2020.

Coverage begins on the first day of the month following approval by ReliaStar Life and payment of first premium. Coverage continues with no decrease in benefits until you reach age 75. At 75, benefits reduce to 50% of original face amount. At 80, benefits reduce to 25% of original face amount. At 85 and after, benefits will be a maximum of $2,500.00. Coverage cannot be canceled as long as you remain a member of the MNCPA, pay your premiums when due and the group policy remains in force.

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. It is not a contract. Terms and conditions of coverage are set forth in group policy 64269-0 issued to the Minnesota Society of Certified Public Accountants. Full details are contained in the Certificate of Insurance, which will be issued to persons who become insured under the Plan. This Plan may not be available to residents of all states. Availability may change.

*MNCPA member's spouse/domestic partner ONLY can apply for coverage starting at age 45 (and they must apply before 74).

MNCPA members can apply for coverage starting at 50 (and they must apply for coverage before 74).

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 1-800-732-8350.

Policy Form LP08GP

How to Apply

1. Complete, date and sign the Application included in the package. 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:
   MNCPA Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

This is a paid endorsement. The MNCPA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

Administered by:

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

QUESTIONS?
1-800-732-8350
www.mncpa-insurance.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

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