Group Term Life Application for 10-Year or 20-Year Level Term Rate

STARR WRIGHT USA
FEDERAL EMPLOYEE PROGRAM ADMINISTRATOR

Please complete the entire application. If completing this application in paper format, please print clearly in dark ink and mail to ***Starr Wright USA Insurance Plan Administrator, 6110 Parkland Blvd., Cleveland, OH 44124. Phone 877-966-3690, Fax: 440-646-9339. You may also apply at www.wrightusa.com.***

Civil Service Employees Benefit Association **67182-7**

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	Social Security Number
Address	City		State	Zip
Date of Birth (MM/DD/YYYY)	Place of Birth	Home/Cell Phone #	Work Phone #	E-mail Address
Agency Name		Occupation		

How did you hear about WrightUSA? □ New Employee Orientation (NEA) □ Agency Benefits Office □ Mail Advertisement
□ Open Season Event □ Coworker □ Other (please specify) : _____

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

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

Dependent Child(ren)'s Information *(complete this section only if applying for Dependent Child(ren) on this application)*:

Number of eligiblechildren:_____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____

Address	City	State	Zip	Home/Cell Phone #

	Member	**Spouse**
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?	❑ Yes ❑ No	❑ Yes ❑ No
Date of last use (month/year):	_____/_____	_____/_____
b) Are you currently working less than 17.5 hours per week at your regular occupation and place of business?	❑ Yes ❑ No	❑ Yes ❑ No
c) 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:_____

2. SELECT YOUR COVERAGE

❑ **10-Year Level Term**
❑ **20-Year Level Term**

Member Amount

❑ $250,000
❑ $500,000
❑ $1,000,000
❑ Other: $_____ *in $25,000 increments*
(Minimum: $100,000 Maximum: $1,000,000)

❑ **10-Year Level Term**
❑ **20-Year Level Term**

Spouse Amount

❑ $250,000
❑ $500,000
❑ $1,000,000
❑ Other: $_____ *in $25,000 increments*
(Minimum: $100,000 Maximum: $1,000,000)

Please select if you wish to include additional options with your coverage*:*

❑ $10,000 Dependent Child(ren) Coverage*

* If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION

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

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member:_____ Spouse:_____

_____ _____

	Member	**Spouse**
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	❑ Yes ❑ No	❑ Yes ❑ No
2) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack) , sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?…..……..	❑ Yes ❑ No	❑ Yes ❑ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?……..	❑ Yes ❑ No	❑ Yes ❑ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?……..	❑ Yes ❑ No	❑ Yes ❑ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?.....	❑ Yes ❑ No	❑ Yes ❑ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?.....	❑ Yes ❑ No	❑ Yes ❑ No
3) 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
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?.....	❑ Yes ❑ No	❑ Yes ❑ No
5) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?.....	❑ Yes ❑ No	❑ Yes ❑ No
6) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations? …….....	❑ Yes ❑ No	❑ Yes ❑ No
a. Member's driver's license number and state of issue:_____		
b. Spouse's driver's license number and state of issue:_____		
7) Have you ever applied for insurance that was declined, postponed or modified in any way?.....	❑ Yes ❑ No	❑ Yes ❑ No
8) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above? ……..	❑ 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				

PLEASE COMPLETE AND SIGN END OF APPLICATION

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, Social Security Number, and Phone Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. 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 FOLLOWNG PAYMENT OPTION SECTION

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

□ **Option 1:** **ELECTRONIC FUNDS TRANSFER (EFT):** □ Monthly □ Quarterly

I request and authorize Starr WrightUSA Insurance Plan Administrator to make withdrawals against the account specified on the attached □ voided check □ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X_____ ___/___/_____

Accountholder's Signature Date

□ **Option 2:** **DIRECT BILL:** □ Quarterly □ Semi-Annual □ Annual

Billing dates will begin after coverage is approved and initial premium has been received.

PLEASE COMPLETE AND SIGN END OF APPLICATION

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 form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Member's Signature	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.