ReliaStar Life Insurance Company
Security Life of Denver Insurance Company
Members of the Voya family of companies

Individual Life Insurance Application

Variable and General Account Products

For your convenience, this Application Package contains 8 forms:

- Individual Life Insurance Application: *Pages 1 - 8*
- Short Form Request for Individual Tax Return Transcript: *4506T-EZ*
- Part II - Medical Declarations: *Part II - Pages 1-2*
- Temporary Insurance Receipt: *Appendix A (2 copies)*
- Agent's Report: *Appendix B*
- Authorization for Release of Health Related Information: *Appendix C*
- Important Notices: *Appendix D*
- Electronic Funds Transfer: *Appendix E*

RETIREMENT | INVESTMENTS | INSURANCE

VOYA FINANCIAL™

Agent's Checklist:

- ☐ Underwriting Company, Product, Product Type, Base Coverage, and Death Benefit questions have been completed.
- ☐ Supplemental Rider options have been selected.
- ☐ Required personal information for the Proposed Primary Insured has been completed.
- ☐ Required information for Primary and Contingent Beneficiaries has been completed.
- ☐ Questions regarding existing life insurance have been completed and detailed properly. If any are marked "Yes", complete all required replacement forms.
- ☐ Personal History Information and Medical Declarations have been completed and detailed thoroughly, where applicable.
- ☐ The "Signed At" and "Date" fields have been completed along with appropriate signatures under the Authorization and Acknowledgement section.
- ☐ The IRS form 4506T-EZ is required with all applications in which the proposed insured is between the ages of 18 to 85 AND the underwriting risk amount is equal to or greater than $3,000,001.
- ☐ The Agent's Report has been completed and submitted with the application.
- ☐ When applicable, the Electronic Funds Transfer form has been completed.
- ☐ An Authorization for Release of Health-Related Information has been submitted for each Proposed Insured/Proposed Other Insured with the application.
- ☐ Appendices A, C and D have been given to the Proposed Insured.
- ☐ A copy of this application has been provided to the Owner and/or Proposed Primary Insured.
- ☐ Applicable state required notices were provided at time of application. Refer to the Forms Wizard tool on the Voya for Professionals website, via Voyaprofessionals.com, for the forms required by state.

Reminders:

- Do not use pencil or correction fluid.
- Do not waive any of our requirements or any information that we request. You do not have the authority to make or modify contracts.
- Do not promise or imply that we will provide insurance.
- DO NOT ACCEPT MONEY OR ISSUE THE TEMPORARY INSURANCE RECEIPT if any representations in the Temporary Insurance Receipt (Appendix B) are answered **"Yes"** or **left blank**.
- Do not accept payment in the form of cash/currency or traveler's checks.
- Do not accept a check or money order made payable to you or with the payee left blank.
- Do not accept payment if the Proposed Primary Insured's age, at the nearest birthday, exceeds 70 years or is less than 15 days.

Mail or fax all completed materials to Customer Service

Mail to: Customer Service, PO Box 5075, Minot, ND 58702-5075

Fax to: 866-308-7743; Attn: Customer Service

Get confirmation from your General Agent to send applications directly to us.

INDIVIDUAL LIFE INSURANCE APPLICATION

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 8055 East Tufts Ave., Suite 710, Denver, CO 80237
A member of the Voya family of companies
(the "Company")

PART I - A. PRODUCT INFORMATION

1. Product Requested ________________ 2. Product Type: ☐ General Account ☐ Variable Account

If applying for a variable life insurance policy, the proposed owner must receive a current prospectus and complete the Fund Allocation of Premium Payments form. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS AND THE CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNTS. AN ILLUSTRATION OF BENEFITS, INCLUDING DEATH BENEFITS, POLICY VALUES AND CASH VALUES, IS AVAILABLE UPON REQUEST.

3. Base Coverage: $ ________________ *(Not including Term Riders - See Section B for Adjustable Term Insurance Rider.)*

4. Death Benefit Option: *(If no option is selected, option will default to A.)*
☐ A or 1 - Level ☐ B or 2 - Increasing or Variable
☐ C or 3 - Face Amount + Premium ☐ D or 4 - Face Amount + Premium + Interest ________ %

5. Death Benefit Qualification Test: *(If no option is selected, option will default to Guideline Premium Test.)*
☐ Guideline Premium Test ☐ Cash Value Accumulation Test

6. Is the insurance employer-sponsored? . . . . ☐ Yes ☐ No

7. List all applications that are concurrently being submitted to Voya for the Insured's family members and/or business partners.

Company Name ________________ Amount $ ________________

Company Name ________________ Amount $ ________________

If the policy will be owned by a "Funded ERISA Plan", complete question 8, specify the plan and trust type and provide the other information requested.

8. Is the insurance for a tax-qualified, pension, profit sharing or defined contribution ERISA plan, or a VEBA or welfare benefit arrangement? . . . . ☐ Yes ☐ No

Plan Provider Name ________________

☐ Tax-qualified plan *(specify profit sharing, defined benefit, or defined contribution)* ________________

☐ Section 419/419A(f)(6) welfare benefit or VEBA plan ☐ Other *(specify type and name of plan)* ________________

PART I - B. RIDER INFORMATION

(Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)

Signed illustration is required for permanent products.

☐ Accidental Death Benefit Rider $ ________
☐ Additional Insured Rider *(Complete Part I - D.)* $ ________
☐ Adjustable Term Insurance Rider
(Specify Target Death Benefit) ________ $ ________
☐ Children's Insurance Rider
(Complete Children's Insurance Rider Application.)
☐ Guaranteed Death Benefit Rider *(An option below must be selected.)*
☐ Lifetime ☐ 20-Year ☐ To age 65 or 20 years, if later
☐ Guaranteed Minimum Accumulation Benefit Rider

☐ Waiver of Cost of Insurance Rider
☐ Waiver of Monthly Deduction Rider
☐ Waiver of Premium *(Term only)*
☐ Waiver of Specified Premium Total Disability Rider
(Specify monthly premium - illustration required) $ ________
☐ Waiver of Surrender Charge Rider
☐ Other ________
☐ Other ________
☐ Other ________

PART I - C. PROPOSED PRIMARY INSURED INFORMATION

1. First Name ________ MI ________ Last Name ________

2. Birth Date ________ SSN ________ Birth State/Country ________ Gender: ☐ M ☐ F

3. Residence Address *(PO Boxes are not permitted.)* ________

City ________ State ________ ZIP ________

4. Daytime Phone (____)________ Evening Phone (____)________

5. Best Time to Call ________ E-mail ________

6. Are you a U.S. Citizen? *(If "No", complete the Foreign Travel and Residence Questionnaire.)* . . . . . . ☐ Yes ☐ No

7. Occupation/Duties ________

8. Employer ________ Phone (____)________

PART I - C. PROPOSED PRIMARY INSURED INFORMATION *(CONTINUED)*

9. Employer Address ______

10. Do you currently use or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . ☐ Yes ☐ No

If "Yes", indicate Type ______ Amount & Frequency ______ Month/Year Last Used ______

11. Driver's License Number ______ 12. Driver's License State ______
(If you do not have a driver's license, then provide government photo ID #, issuer and expiration date.)

13. Name on Driver's License *(if different than above)* ______

PART I - D. PROPOSED OTHER INSURED INFORMATION

1. First Name ______ MI ______ Last Name ______

2. Birth Date ______ SSN ______ Birth State/Country ______ Gender: ☐ M ☐ F

3. Residence Address *(PO Boxes are not permitted.)* ______

City ______ State ______ ZIP ______

4. Daytime Phone (____)______ Evening Phone (____)______

5. Best Time to Call ______ E-mail ______

6. Are you a U.S. Citizen? *(If "No", complete the Foreign Travel and Residence Questionnaire.)*. . . ☐ Yes ☐ No

7. Occupation/Duties ______

8. Employer ______ Phone (____)______

9. Employer Address ______

10. Do you currently use or have you ever used tobacco or nicotine products in any form? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . ☐ Yes ☐ No

If "Yes", indicate Type ______ Amount & Frequency ______ Month/Year Last Used ______

11. Driver's License Number ______ 12. Driver's License State ______
(If you do not have a driver's license, then provide government photo ID #, issuer and expiration date.)

13. Name on Driver's License *(if different than above)* ______

PART I - E. PROPOSED OWNER/TRUST/CORPORATION INFORMATION *(If Proposed Owner is a Trust or Corporation, provide first and last pages of the Trust document, including signatures. The Trust must be established prior to the application date.)*

1. Full Name of Owner/Trust/Corporation *(30 character limit)* ______

2. Owner Relationship to Proposed Primary Insured ______

3. Owner Birth Date ______ Owner Phone (____)______ Owner SSN/TIN ______

4. Owner Address *(PO Boxes are not permitted.)* ______

City ______ State ______ ZIP ______

5. Corporation Contact Name ______

6. Address of Trust/Corporation ______

7. Billing Address ______

8. Type of Government Issued ID (Driver's License/Passport) ______ Document Number ______

Issuing State or Country ______ Issuance Date ______ Expiration Date ______

9. Trust Contact Name ______ TIN ______ Trust Date ______

10. Purpose of the Trust ______ Type of Trust: ☐ Revocable ☐ Irrevocable

11. State of Incorporation ______ Trustee/Corporate Officer Name ______

12. Does the above trustee have sole authority to act on behalf of the Trust? . . . ☐ Yes ☐ No
(If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees on the application.)

PART I - F. BENEFICIARY INFORMATION

Unless otherwise stated, the beneficiary designation is revocable and beneficiaries of like class shall share rights of survivorship equally. If Trust or Corporation, provide name and date of trust agreement and state of incorporation. Percentages must total 100%, using whole percentages only. If additional space is needed, use Section Q.

1. Is the Beneficiary a Trust? . . . . ☐ Yes ☐ No

2. Trust Name ____________ Trust Date ____________ State of Incorporation ____________

	Name (First, MI, Last)	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
Proposed Primary Insured			☐ Male ☐ Female				☐ Primary ☐ Contingent
			☐ Male ☐ Female				☐ Primary ☐ Contingent
			☐ Male ☐ Female				☐ Primary ☐ Contingent
			☐ Male ☐ Female				☐ Primary ☐ Contingent
Proposed Other Insured			☐ Male ☐ Female				☐ Primary ☐ Contingent
			☐ Male ☐ Female				☐ Primary ☐ Contingent
			☐ Male ☐ Female				☐ Primary ☐ Contingent
			☐ Male ☐ Female				☐ Primary ☐ Contingent

PART I - G. PERSONAL HISTORY *(Questions 1-7 must be completed for all Proposed Insureds.)*

Question	Proposed Insured	Proposed Other Insured
1. Are you, or do you intend to become a member of the armed forces, including the Reserves, or on alert? *(If "Yes", complete Military Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you intend to travel or reside outside the United States or Canada in the next two years? *(If "Yes", complete the Foreign Travel and Residence Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? *(If "Yes", complete the Aviation Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? *(If "Yes", complete the appropriate questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes or dune buggies? *(If "Yes", complete Avocations and Professional Sports Questionnaire.)*	☐ Yes ☐ No	☐ Yes ☐ No
6. Except for traffic violations, have you been convicted in a criminal proceeding or been the subject of a pending criminal proceeding?	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle?	☐ Yes ☐ No	☐ Yes ☐ No

For any "Yes" answer to questions 6-7, please record information in the chart below.

Question	Proposed Insured/Proposed Other Insured	Explanation

PART I - H. PAYMENT INFORMATION

1. Initial Payment: ☐ Check ☐ Cash on Delivery ☐ 1035 Exchange ☐ Voya Internal or Affiliated Exchange/Surrender

2. Initial Payment Amount $__________ Planned/Scheduled/Modal Payment $__________

3. Frequency of Subsequent Payments: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly[1]

☐ Military Allotment[2] *(Active or retired military members must complete the Military Allotment form and return it to the military finance department.)*

☐ Civil Service Allotment *(The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)*

[1] *Available with electronic funds transfer.*
[2] *Two monthly premium payments are required before the policy becomes active.*

PART I - I. LIST BILL INFORMATION - EMPLOYER-SPONSORED PLANS ONLY *(For a new List Bill Plan, please contact the List Bill Department at 877-886-5050.)*

1. List Bill/File Code # *(if plan already exists)* __________

2. Employer Plan Name *(if plan already exists)* __________ 3. Phone __________

4. Address __________

City __________ State __________ ZIP __________

PART I - J. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? ☐ Yes *(If "Yes", review the policy backdating notice below.)*

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

I understand, on backdated policies, that the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

PART I - K. FINANCIAL DETAILS

1. Will the applicant accept this policy if it is a "Modified Endowment Contract" at issue? ☐ Yes ☐ No
2. Is the policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No
3. Do you believe you have the financial ability to continue making premium payments on this policy? ☐ Yes ☐ No
4. Have you or your company ever declared bankruptcy? *(If "Yes", provide details including date discharged.)* ☐ Yes ☐ No

____

5. Personal Insurance *(For Personal Insurance complete questions 5-7; for Business Insurance complete questions 8-11.)*
☐ Estate Liquidity ☐ Family Protection ☐ Tax Planning ☐ Retirement Planning ☐ Cash Accumulation
☐ Other __________

6.	Annual Earned Income	Annual Interest and Other Income
Proposed Primary Insured		
Proposed Other Insured		

7. Total Assets $__________ Total Liabilities $__________ Total Net Worth $__________

PART I - K. FINANCIAL DETAILS *(CONTINUED)*

8. Business Insurance: ☐ Buy/Sell ☐ Key Person ☐ Other ______

9. Total Business Assets $ ______ Total Business Liabilities $ ______ Total Business Net Worth $ ______

10. Business Net Profit After Taxes for Past Two Years: Last Year $ ______ Previous Year $ ______

11. Owner Name	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?
		$	%	☐ Yes ☐ No
		$	%	☐ Yes ☐ No

PART I - L. IN FORCE/REPLACEMENT INFORMATION *(Questions 1-3 must be completed for each Proposed Insured/Other Insured/Owner.)*

	Proposed Insured Yes	Proposed Insured No	Proposed Other Insured Yes	Proposed Other Insured No	Proposed Owner Yes	Proposed Owner No
1. Do you currently have life insurance inforce or applied for? *(If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)*	☐	☐	☐	☐	☐	☐

Insured Name	Insurance Company (Do not include group policies.)	Policy Number	Amount	Date Issued

	Proposed Insured Yes	Proposed Insured No	Proposed Other Insured Yes	Proposed Other Insured No	Proposed Owner Yes	Proposed Owner No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*	☐	☐	☐	☐	☐	☐
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes", complete state required replacement form and provide details below.)*	☐	☐	☐	☐	☐	☐

4. For any "Yes" answer to questions 2-3, provide details regarding the policies being replaced in the chart below.

Insured Name	Insurance Company	Policy Number	Amount

5. Is this insurance intended to be a tax free or 1035 Exchange? *(1035 not available on term insurance)* . . . ☐ Yes ☐ No

6. If "Yes", will a policy loan be carried over? . . . ☐ Yes ☐ No

PART I - M. MEDICAL TRANSFER STATEMENT *(Complete when submitting medical examinations of another insurance company.)*

1. Insurance Company Name ______ 2. Examination Date ______

	Proposed Insured Yes	Proposed Insured No	Proposed Other Insured Yes	Proposed Other Insured No
3. To the best of your knowledge and belief, are the statements in the examination true and complete today?	☐	☐	☐	☐
4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 1 above? *(If "Yes", complete Part II - Medical Declarations.)*	☐	☐	☐	☐

PART I - N. SUITABILITY/NEEDS ANALYSIS - VARIABLE PRODUCTS ONLY *(Completed by the Proposed Owner. Failing to provide this information will result in a delay in the issuing of new business.)*

1. Have you received a current prospectus including supplements for the variable life insurance policy? . . . . ☐ Yes ☐ No

   Provide date of policy prospectus/supplement ______________________

2. Do you understand that:

   a. The amount or duration of the policy death benefit may vary under specified conditions; **Policy values may increase or decrease with the investment experience of the variable investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division and/or the Indexed Credit Strategy, if applicable; The amount payable is not guaranteed, but is dependent on the account value and amounts owed under the policy?** . . . . ☐ Yes ☐ No

   b. The fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? . . . . ☐ Yes ☐ No

   c. Personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience of the variable investment options or of actual interest credited in the general account option(s)? . . . . ☐ Yes ☐ No

PART I - O. TELEPHONE PRIVILEGES - INDEXED AND VARIABLE PRODUCTS ONLY

I understand that I may indicate below whether to allow telephone privileges to be provided to me and/or my agent/registered representative and his/her assistant. Telephone privileges allow an authorized person to call the Company to make certain elections and request certain transactions. The Company may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. By accepting telephone privileges, I authorize the Company to record my telephone calls to the Company. The Company and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be genuine.

I understand that if I do not want to authorize telephone privileges, I should not check either of the two boxes below. I also understand that once granted, such privileges will be revoked by upon receipt by the Company of signed, written instructions to terminate telephone privileges.

☐ I want telephone privileges.

☐ I want telephone privileges granted to my agent/registered representative and his/her assistant.

PART I - P. REPLACEMENT VERIFICATION *(For Agent use ONLY)*

1. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? *(If "Yes", submit state required replacement forms.)*. . . . . ☐ Yes ☐ No

   a. Is the applicant considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating their existing policy or contract? *(If "Yes", complete state required replacement form and provide details below.)* . . . . ☐ Yes ☐ No

   b. Is the applicant considering using funds from their existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes", complete state required replacement form.)* . . . . ☐ Yes ☐ No

   Company ______________________ Policy Number ______________ Amount $ ______________

PART I - Q. NOTES

Use this space to provide any additional details to questions answered throughout the application. Please understand that if you provide the Company with information on this page it will be considered part of your Individual Life Insurance Application.

Section	Question	Details

PART I - R. VOYA'S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI)

As established leaders in the financial services industry, the Company along with other Voya Life Companies strongly opposes arrangements designed to obtain life insurance for the benefit of a third party that lacks an insurable interest in the insured. We believe this position supports the best interests of our policy owners, as these stranger-owned or stranger-originated life insurance transactions ("STOLI") will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business.

To help prevent STOLI and protect our policy owners, we require that all parties confirm they have read and will abide by the Company's policy on STOLI arrangements. The Company will seek to rescind or cancel the insurance coverage of any contract where material misrepresentation occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

Company appointed producers are prohibited from selling any Company life insurance product and an applicant may not purchase a product in the following circumstances:

- If, at the time of sale, a plan exists to directly or indirectly sell, assign, settle or otherwise transfer the policy (or the rights to its death benefits), or an ownership or beneficial interest in an entity that will own the policy, to a life settlement company or other third party;
- If, in connection with the sale, the policy owner and/or insured is offered any consideration or inducement, including, but not limited to, cash payments, "free" or "no cost" insurance;
- Using a sales concept, design, marketing plan, marketing material or other program (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending) that has not been made available by the Company; or
- Where the producer and/or applicant knows, or has reason to know that the true source of funds (e.g., premium financing, third party funding) for premium payments of a policy have not been disclosed to the Company.

Company appointed producers are also prohibited from providing, or aiding and abetting the provision of, fraudulent or misleading answers to application or inspection questions, including, but not limited to, questions on the Agent Report section.

Participation in a Prohibited Practice May Result in Disciplinary Action to Producers.

Producers involved in any prohibited practice will be subject to contract and appointment termination, including termination for cause, which may include loss of all current and future commissions. The Company will also report cases of fraud and material misrepresentation to state fraud departments for investigation and potential regulatory action.

By my signature in Section S on this application, I affirmatively represent that I have read the Company's policy on STOLI arrangements set forth above, that I have not engaged in any prohibited conduct described above in connection with this application, and that I will abide by the policy on STOLI arrangements.

PART I - S. AUTHORIZATION AND ACKNOWLEDGEMENT

Verification. By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and declare that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. Unless otherwise stated in a Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, and the first premium is received by the Company while the Proposed Insured is alive. If I have paid premium with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

Statements of Understanding. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original. I give my permission to the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied.

I acknowledge receipt of the following disclosures and notices: Accelerated Benefit Rider and Critical Illness Disclosures, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. I certify, under penalty of perjury, that my Social Security Number/tax identification number is shown and is correct and that I am not subject to back-up withholding.

PART I - S. AUTHORIZATION AND ACKNOWLEDGEMENT *(Continued)*

If an investigative consumer report is prepared, I request to be interviewed. ☐ **Yes** ☐ **No**

Daytime phone number: ( ) .

Contact me between the hours of ___ a.m./p.m. and ___ a.m./p.m.

By signing below I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:

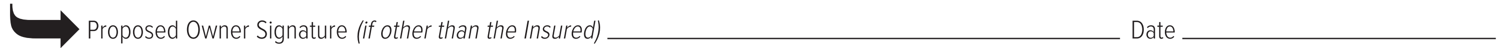
Governing Law. The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

Jurisdiction. Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

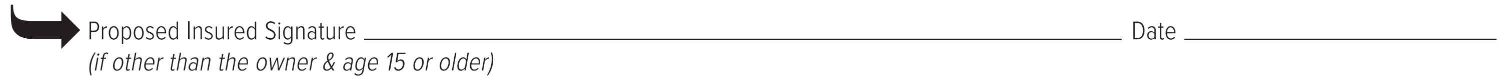
All completed materials must be sent to Customer Service at: 2000 21st Ave. NW, Minot, ND 58703

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

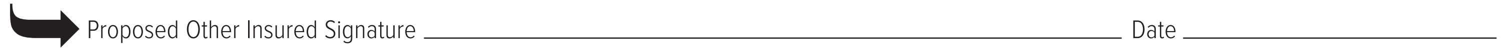
Proposed Owner Signed at *(city/state)* ______________________ Date ____________



Proposed Owner Signature *(if other than the Insured)* ______________________ Date ____________



Proposed Insured Signature ______________________ Date ____________
(if other than the owner & age 15 or older)



Proposed Other Insured Signature ______________________ Date ____________

Proposed Owner/Trustee Name *(please print)* ______________________

Parent or Guardian Signature ______________________
(if the Proposed Owner or the Proposed Primary Insured is a minor)

Writing Agent/Registered Rep. Signature ______________________ Date ____________

Writing Agent State Lic. Number ____________ Writing Agent/Registered Rep. Number ____________

Agent/Registered Rep. Name ______________________

Agent State Lic. Number ____________ Agent/Registered Rep. Number ____________

Agent/Registered Rep. Name ______________________

Agent State Lic. Number ____________ Agent/Registered Rep. Number ____________

Form **4506T-EZ**

(Rev. January 2012)

Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

▶ **Request may not be processed if the form is incomplete or illegible.**

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number or individual taxpayer identification number on tax return**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name **Voya Life Companies**
c/o LexisNexis Risk Solutions

Telephone number **Phone: 561-999-4000**
Fax: 877-832-3615

Address (including apt., room, or suite no.), city, state, and ZIP code

6601 Park of Commerce Blvd., Boca Raton, FL 33487
UID: IRSVERIFY1

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

______ ______ ______ ______

☐ Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return.

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS may notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** husband or wife must sign. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) Date

▶ **Spouse's signature** Date

Section references are to the Internal Revenue Code unless otherwise noted.

What's New

The IRS has created a page on IRS.gov for information about Form 4506T-EZ at *http://www.irs.gov/form4506*. Information about any recent developments affecting Form 4506T-EZ (such as legislation enacted after we released it) will be posted on that page.

Caution. Do not sign this form unless all applicable lines have been completed.

Purpose of form. Individuals can use Form 4506T-EZ to request a tax return transcript for the current and the prior three years that includes most lines of the original tax return. The tax return transcript will not show payments, penalty assessments, or adjustments made to the originally filed return. You can also designate (on line 5) a third party (such as a mortgage company) to receive a transcript. Form 4506T-EZ cannot be used by taxpayers who file Form 1040 based on a tax year beginning in one calendar year and ending in the following year (fiscal tax year). Taxpayers using a fiscal tax year must file Form 4506-T, Request for Transcript of Tax Return, to request a return transcript.

Use Form 4506-T to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on “Order a Transcript” or call 1-800-908-9946.

Where to file. Mail or fax Form 4506T-EZ to the address below for the state you lived in when the return was filed.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

If you filed an individual return and lived in:	Mail or fax to the “Internal Revenue Service” at:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301 512-460-2272
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888 559-456-5876
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 816-292-6102

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506T-EZ must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the information be sent to a third party, the IRS must receive Form 4506T-EZ within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506T-EZ exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. If you request a transcript, sections 6103 and 6109 require you to provide this information, including your SSN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506T-EZ will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 9 min.; **Preparing the form,** 18 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506T-EZ simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Products Coordinating Committee
SE:W:CAR:MP:T:M:S
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

INDIVIDUAL LIFE INSURANCE APPLICATION PART II - MEDICAL DECLARATIONS

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 8055 East Tufts Ave., Suite 710, Denver, CO 80237
A member of the Voya family of companies

For any proposed insured not completing a separate Part II Medical Examination, questions 1-16 below must be completed. Provide names and other data of Proposed Insured and all Proposed Other Insureds.

Proposed Primary Insured

1. Height ____________ Weight ____________ Loss or gain in pounds during the last year ____________
2. Personal Physician Name ____________ Physician Phone (______)____________
3. Physician Address ____________ City ____________ State ______ ZIP ______
4. Date last seen by Physician ____________ 5. Reason for Consultation ____________
6. Results of Consultation ____________

Proposed Other Insured

7. Height ____________ Weight ____________ Loss or gain in pounds during the last year ____________
8. Personal Physician Name ____________ Physician Phone (______)____________
9. Physician Address ____________ City ____________ State ______ ZIP ______
10. Date last seen by physician ____________ 11. Reason for Consultation ____________
12. Results of Consultation ____________

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

For any “Yes” answer to questions 13-15 please record information in chart below.

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

16. Family History							
Proposed Insured				Proposed Other Insured			
	Age if Living	Age at Death	Cause of Death		Age if Living	Age at Death	Cause of Death
Father				Father			
Mother				Mother			
Brother(s)				Brother(s)			
Sister(s)				Sister(s)			

I have read the statements above and affirm that they are complete and true to the best of my knowledge and belief.

Signed at *(city, state)* ______________________________ Date ______________

Proposed Insured Signature *(if age 15 or older)* ______________________________ Date ______________

Proposed Other Insured Signature ______________________________ Date ______________

Parent or Guardian Signature *(if the Proposed Primary Insured is a minor)* ______________________________ Date ______________

TEMPORARY INSURANCE RECEIPT

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 8055 East Tufts Ave., Suite 710, Denver, CO 80237
(the "Company")

I. PREMIUM RECEIPT *(On the lives of the Proposed Primary Insured and Proposed Other Insured named below)*

Amount Received $ ______________ Date ______________ Policy Application Date ______________

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS *(For each Proposed Insured named below)*

1. Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
   a. any type of heart disease, stroke or other vascular disease? ☐ Yes ☐ No
   b. any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system? ☐ Yes ☐ No
2. In the past five years has any Proposed Insured experienced unintentional weight loss? ☐ Yes ☐ No
3. Has any Proposed Insured attained age 70?. ☐ Yes ☐ No

III. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders covering the life or lives of the Proposed Insured(s) if issued as applied for under the Application; or (b) $1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed $1,000,000; and the $1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage.

If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the issue date, premiums are due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.

There is no temporary insurance receipt coverage if:

- **Any of the above representations is answered YES or LEFT BLANK.**
- **If Section 1035 exchange paperwork is received without premium payment.**
- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name *(please print)* ______________ Signed at *(city/state)* ______________

➡ Proposed Owner Signature ______________ Date ______________

Proposed Insured Name *(please print)* ______________ Signed at *(city/state)* ______________

➡ Proposed Insured Signature
(if other than the Proposed Owner) ______________ Date ______________

Proposed Other Insured Name *(please print)* ______________ Signed at *(city/state)* ______________

➡ Proposed Other Insured Signature ______________ Date ______________

Writing Agent Name *(please print)* ______________ Agent Phone ______________

➡ Writing Agent Signature ______________ Date ______________

1ST COPY TO CUSTOMER SERVICE 2ND COPY TO PROPOSED INSURED

TEMPORARY INSURANCE RECEIPT

☐ **ReliaStar Life Insurance Company,** 20 Washington Avenue South, Minneapolis, MN 55401
☐ **Security Life of Denver Insurance Company,** 8055 East Tufts Ave., Suite 710, Denver, CO 80237
(the "Company")

I. PREMIUM RECEIPT *(On the lives of the Proposed Primary Insured and Proposed Other Insured named below)*

Amount Received $ ______________ Date ______________ Policy Application Date ______________

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS *(For each Proposed Insured named below)*

1. Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
   a. any type of heart disease, stroke or other vascular disease? ☐ Yes ☐ No
   b. any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system? ☐ Yes ☐ No
2. In the past five years has any Proposed Insured experienced unintentional weight loss? ☐ Yes ☐ No
3. Has any Proposed Insured attained age 70?. ☐ Yes ☐ No

III. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders covering the life or lives of the Proposed Insured(s) if issued as applied for under the Application; or (b) $1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed $1,000,000; and the $1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage.

If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the issue date, premiums are due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.

There is no temporary insurance receipt coverage if:
- **Any of the above representations is answered YES or LEFT BLANK.**
- **If Section 1035 exchange paperwork is received without premium payment.**
- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name *(please print)* ______________ Signed at *(city/state)* ______________

➡ Proposed Owner Signature ______________ Date ______________

Proposed Insured Name *(please print)* ______________ Signed at *(city/state)* ______________

➡ Proposed Insured Signature
(if other than the Proposed Owner) ______________ Date ______________

Proposed Other Insured Name *(please print)* ______________ Signed at *(city/state)* ______________

➡ Proposed Other Insured Signature ______________ Date ______________

Writing Agent Name *(please print)* ______________ Agent Phone ______________

➡ Writing Agent Signature ______________ Date ______________

1ST COPY TO CUSTOMER SERVICE 2ND COPY TO PROPOSED INSURED

AGENT'S REPORT

To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.

Agent Name/Broker-Dealer *(please print)*	Agent ID Number	% Split	General Agent Number	General Agent Name

A. COMPLIANCE INFORMATION

1. Did you meet personally with the Proposed Owner and review their government issued ID? *(If "No", explain in Section D.)* . . . . ☐ Yes ☐ No
2. Did you obtain the Proposed Insured's Medical Declarations in person and record them in the presence of the Proposed Insured? *(If "No", explain in Section D and arrange for an exam.)*. . . . . ☐ Yes ☐ No
3. Was an initial premium payment accepted? . . . . ☐ Yes ☐ No
   If "Yes", was the Temporary Insurance Receipt completed and delivered to the Proposed Insured or Proposed Owner?. . . . . ☐ Yes ☐ No
4. Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner?. . . . . ☐ Yes ☐ No
5. Has the Proposed Owner or Proposed Insured previously sold or assigned a policy to a life settlement or viatical company? . . . . . ☐ Yes ☐ No
   If "Yes", provide details. ____________________
6. Will financing *(using any source other than the client's assets)* of premium payments be used now or is it contemplated within the next two years? . . . ☐ Yes ☐ No
   a. If "Yes", complete the Financing Disclosure & Acknowledgment.
   b. If "No", what is the source of funds used to pay premiums on this policy? (Check all that apply below.)

	Initial	Future
Current income	☐	☐
CDs or savings	☐	☐
Mutual funds or brokerage account	☐	☐
Existing life insurance policy(ies) or annuity contract(s)	☐	☐
Other	☐ ____________	☐ ____________

B. PROPOSED INSURED/OWNER INFORMATION

1. How long have you known the Proposed Insured? ____________ 2. Are you related? ☐ Yes ☐ No How? ____________
3. How much life insurance is in force on the Proposed Insured's spouse/domestic partner, payable to the Proposed Insured or other dependents? $____________
4. What is the annual income of the Proposed Insured's spouse or domestic partner? $____________
5. If this application is for a juvenile, indicate the amount of life insurance in force on each parent or sibling.
   Father $ ____________ Mother $ ____________ Sibling $ ____________
6. If underwriting requirements were ordered, which paramedical vendor was used? ____________

C. RELATED APPLICATIONS *(List all applications that are concurrently being submitted to Voya for the Insured's family members and/or business partners.)*

Proposed Insured Names and Amounts applied for ____________________

D. REMARKS *(Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.)*

E. ACKNOWLEDGEMENT AND SIGNATURE

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

I certify that all sales materials used during this sale were approved by the Company. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Company's corporate policy. I acknowledge that I have delivered the Important Notices (Consumer Privacy Notice & MIB) to the Proposed Insured(s) or Proposed Owner. I affirm that the answers above are complete and true to the best of my knowledge and belief.

Agent Signature(s) ____________________ Date ____________

Contact for Requirements ____________________ Agent SSN *(Optional - Last 4 digits only)* ____________

Agent Phone ____________ Fax ____________ E-mail ____________

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION *(HIPAA compliant)*

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(Please print.)* ______________________________

Birth Date ______________________________ SSN/ITIN ______________________________

Proposed Insured/Patient Address ______________________________

City ______________________________ State ______________ ZIP __________

AUTHORIZATION INFORMATION

This will authorize: ______________________________ *(Physician, Clinic or Hospital Name)*

to release medical information to ______________________________ *(the Life Insurance Agent/Agency/Carrier(s))*.

Authorized Life Insurance Carrier(s): ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York and Security Life of Denver Insurance Company

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I authorize any organization, insurance company or medically related facility to release to the Life Insurance Carrier named above any and all records and information regarding me, the proposed insured, and any minor children who are to be insured according to the terms of this authorization. This includes records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions or prescription records; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Insurance Agent/Agency/Carrier(s) named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I authorize MIB, Inc. to give to the Life Insurance Carrier(s) named above, or its reinsurers, any records or knowledge of me or my health.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Insurance Agent/Agency/Carrier(s) may provide the information to the listed carrier(s) so that they may: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Insurance Agent/Agency/Carrier(s).

I give my permission to the Life Insurance Carrier named above to send any information obtained to MIB, Inc. or its reinsurers.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Insurance Agent/Agency/Carrier(s) named above at the following address: Attention: Privacy Official, 2000 21st Ave. NW, Minot, ND 58702

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by any applicable state privacy laws, state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Proposed Insured/Patient or
Personal Representative Signature ______________________________ Date ______________

Description of Personal Representative's
Authority or Relationship to Patient *(Please print.)* ______________________________

A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PROPOSED INSURED.

IMPORTANT NOTICES

CONSUMER PRIVACY NOTICE

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, the Company ("we") will send you the name, address, and phone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. 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, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records or by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. 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 the Company unless you request otherwise.

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; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

Notice Regarding MIB, Inc.
(Medical Information Bureau)

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau (MIB), Inc. MIB is a nonprofit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The mailing address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. The phone number is 866-692-6901 and the fax number is 866-346-3642. The MIB website address is www.mib.com.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Federal Regulations - 42CFR Part 2

Your medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. If information is protected by federal or state law, you may revoke this authorization at any time by mailing a written request to the Company. A written request, however, will not apply to any information collected before the date that we receive your request.

IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money-laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you apply for life insurance, we will ask for your name, address, birth date, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to:

Customer Service
Life New Business
PO Box 5053
Minot, ND, 58702-5053

This page must be given to the Proposed Insured.

ACKNOWLEDGEMENTS

Notice Regarding Collection of Information and Information Practices

In order to evaluate your application for life insurance, we must collect information about you and any minor children who are to be insured. The type of information that we may collect includes, but is not limited to, the following: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information about you or your minor children who are to be insured. Some of that information will come from you. Some will come from other sources.

The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically related facilities, insurance or reinsuring companies, Medical Information Bureau ("MIB"), Inc., any consumer reporting agencies, and any other organizations. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

Proposed Insured/Owner: ***By signing Section S on the Individual Life Insurance Application, the Proposed Insured acknowledges receipt of these notices.***

Producer: ***By signing Section S on the Individual Life Insurance Application, the producers acknowledge that a copy of these notices have been provided.***

This page must be given to the Proposed Insured.

ELECTRONIC FUNDS TRANSFER (EFT)

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ Security Life of Denver Insurance Company, Denver, CO
("the Company")
Customer Service, 2000 21st Ave. NW, Minot, ND 58703

This authorization is available for use with all products. The first premium payment will be applied when all policy requirements have been received. A specific draft date for subsequent premium payments can be requested, however, it may cause multiple drafts within the first 30 days.

ELECTRONIC FUNDS TRANSFER (EFT)

What is the EFT plan?
The EFT plan allows us to pay your policy premiums by automatically withdrawing funds from your financial institution's account.

What happens if my financial institution does not honor a withdrawal?
If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. Premium payments are necessary to fund your policy; therefore, you will be required to send us a replacement payment. If we do not receive a replacement payment within the time required by your policy, your policy will enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage. To help prevent this, we encourage you to obtain overdraft protection from your bank.

How much will be deducted from my account?
We will only deduct premium payments according to the payment schedule outlined in your policy.

How can I cancel the EFT plan?
You have two options. You can write to us as the address above. Once we receive your request, we will cancel the plan within 7 – 10 business days. You may also call us at 877-886-5050 to cancel the plan.

We may cancel the plan without notice if a withdrawal is not honored or 30 days after we provide written notice to you.

If the plan is cancelled, you must pay any unpaid and future premiums directly to us on the premium due date. Termination of the plan does not change the premium due dates.

I'd like to enroll. Where do I sign?
Please read the following agreement and sign and date this form.

Authorization Agreement for Prearranged Payments

I authorize the Company to withdraw funds from my checking or savings account, identified on the next page, to pay premiums on my life insurance policy. This authorization will remain in effect until the Company has received a written request or phone call from me to terminate this agreement.

Important Notice for Term Insurance Premiums: Premiums paid more frequently than annually may result in higher total premiums for the same coverage.

This agreement authorizes: ☐ A new monthly transfer ☐ A change in the existing transfer amount ☐ A change in financial institution

Insured's Name *(please print)*	Policy Number	Deduction Amount
		$
		$
		$

Request Specific Draft Date for Recurring Payments[1] *(Between the 1st and 28th)* ____________________

Bank Name ____________________ Account Type: ☐ Checking ☐ Savings

Bank Address ____________________

City ____________________ State __________ Zip ____________________

Name(s) on Account ____________________

[1] Depending on the type of policy you own, the draft date options may vary. Please call us at 877-886-5050 for more information.

Order #153756 09/01/2014

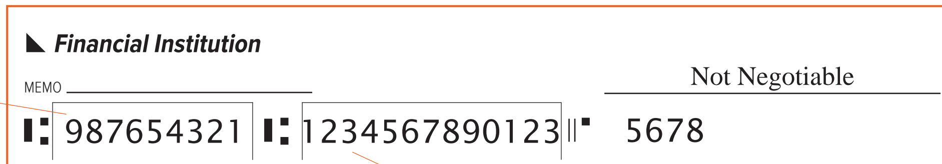
For checking accounts, please tape a voided check in the space below. If you cannot provide these, you may write the bank routing number and account number in the appropriate fields.

Routing Number *(9 digits)* ______________________ Account Number ______________________

SSN/TIN ______________________ Phone ______________________

Sample Check

Routing # (9 digits)



Account #