The Insurance & Benefits Trust of PORAC

Simple, Affordable & SAFE!

Group Term Life Insurance Application

(5-Year Age Banded Rates, 10 & 20-Year Group Level Term Rates)

ReliaStar Life Insurance Company

Box 20 l Minneapolis, MN 55440 l Please complete and sign back of application

P-01_06/12

Group Term Life Application

Reference to Spouse includes Spouse or Domestic Partner

Please complete the entire application. The proposed insured should fill out this application.

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

Myers-Stevens & Toohey & Co., Inc. | 26101 Marguerite Parkway | Mission Viejo | CA 92692

1. Tell us about yourself

Name of Local Association: _____ PORAC #____

Insurance and Benefits Trust of Peace Officers Research Association of California 66326-3

You are applying as: ☐ Association Member ☐ Spouse of Member

Member Name (last, first, middle)			☐ Male ☐ Female ☐ Active ☐ Retired
Date of Birth	Height	Weight	Social Security Number
Home Address			
City		State	ZIP
Home Phone		Work Phone	E-mail Address
Spouse Name (last, first, middle)			Name of Member
Spouse Date of Birth	Spouse Height	Spouse Weight	Spouse Social Security Number

Indicate The Group Term Insurance Plan You Are Applying For:

New Academy Graduate Guaranteed Issue Group Term Life Insurance

Date of Hire _____ ☐ **$250,000**

5-Year Age Banded Rate Plan	☐ **Member**	☐ **Spouse**
10-Year Level Term Rate Plan	☐ **Member**	☐ **Spouse**
20-Year Level Term Rate Plan	☐ **Member**	☐ **Spouse**

➤ Indicate amount of life insurance applied for with this application

Member $ _____ *in $100,000 increments*

Spouse $ _____ *in $50,000 increments*
(Maximum benefit 50% of Members face amount)

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

➤ Matching Accidental Death Benefit ($500,000 Maximum Benefit)
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

➤ Have you used tobacco products of any kind in the last 12 months?
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

➤ Are you currently working at least 30 hours per week at your regular occupation and place of business? Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

➤ Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? If yes, please explain:
Member ☐ Yes ☐ No _____
Spouse ☐ Yes ☐ No _____

Beneficiary Information:

List one or more beneficiaries below. List the percent each will receive. The total must equal 100 percent. *Beneficiary for dependent coverage will be the insured under the certificate to which the dependent coverage is attached. If Spouse is applying for Group Term life insurance, the Spouse must also specify a beneficiary designation.*

Beneficiary for Member Coverage			
Name	Address	Relationship	Percent

Beneficiary for Spouse Coverage (if applying for Group Level Term coverage)			
Name	Address	Relationship	Percent

Provide us with this health information

a.) Have you, for any condition during the past 12 months, consulted a physician/health practitioner, received surgical or medical care, or taken prescribed medication?
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

b.) Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

c.) In the past 5 years have you ever been diagnosed with or been treated for: disease or disorder of heart; lungs; nervous/mental system (including anxiety and depression); liver; kidneys; stomach; colon or genito-urinary system; stroke; high-blood pressure; cancer or tumor; diabetes; or arthritis?
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

d.) In the past 5 years have you ever sought help or received counseling or treatment for alcohol or drug use, or are you currently using illegal drugs?
Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

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

Q#	Name	Conditions/illness/treatment	Date(s) of Treatment	Physician/Health practitioner's name and complete mailing address

e.) List the name and address of your regular physician/health practitioner and the date you last consulted with him/her:

Member _____

Spouse _____

Read this information carefully, then sign and date below:

- To the best of my knowledge and belief, the information I've 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.

Authorization & Acknowledgment – Please Read & Sign Below**.**
For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

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

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

Continued on the next page

the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

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

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

Member Signature	Print Name	Date

Spouse Signature	Print Name	Date

Rates for 5-Year Age Banded Group Annual Term Life Insurance

Rates shown are guaranteed until 09/30/2014. Premiums will increase as you enter a new age bracket. Increases occur on January 1st following age change.

Monthly Premium Rates per $1,000 Benefit

Issue Age	Non-Tobacco User	Tobacco User
Under 30	0.061	0.079
30-34	0.066	0.085
35-39	0.082	0.106
40-44	0.132	0.170
45-49	0.206	0.266
50-54	0.369	0.475
55-59	0.645	0.831
60-64	0.995	1.283
65-69	1.889	2.434
70-74	3.023	3.895
75+	4.239	5.463

Rates for 10-Year Group Level Term for $100,000 - $1,000,000*

Monthly Level Premium Rates per $1,000 *Rates shown are guaranteed until 09/30/2014.*

Monthly Premium

Issue Age	Non-Tobacco User	Tobacco User
18-26	0.046	0.097
27	0.046	0.099
28	0.046	0.103
29	0.046	0.107
30	0.046	0.118
31	0.046	0.124
32	0.046	0.132
33	0.046	0.141
34	0.046	0.150
35	0.046	0.161
36	0.047	0.173
37	0.048	0.186
38	0.051	0.200
39	0.053	0.216
40	0.058	0.233
41	0.063	0.252
42	0.070	0.272
43	0.078	0.293
44	0.086	0.316
45	0.095	0.338
46	0.104	0.360
47	0.113	0.383
48	0.122	0.408
49	0.133	0.436
50	0.147	0.466

(Rates continued on next page for ages 51-59)

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

Rates for 10-Year Group Level Term for $100,000 - $1,000,000*

Monthly Level Premium Rates per $1,000 *Rates shown are guaranteed until 09/30/2014.*

Monthly Premium

Issue Age	Non-Tobacco User	Tobacco User	Issue Age	Non-Tobacco User	Tobacco User
51	0.162	0.500	59	0.353	0.878
52	0.180	0.536	60	0.420	1.089
53	0.199	0.575	61	0.454	1.191
54	0.222	0.617	62	0.485	1.306
55	0.245	0.662	63	0.524	1.439
56	0.268	0.707	64	0.570	1.594
57	0.293	0.754	65	0.641	1.774
58	0.321	0.809			

Rates for 20-Year Group Level Term for $100,000 - $1,000,000*

Monthly Level Premium Rates per $1,000 *Rates shown are guaranteed until 09/30/2014.*

Monthly Premium

Issue Age	Non-Tobacco User	Tobacco User	Issue Age	Non-Tobacco User	Tobacco User
26	0.051	0.112	38	0.068	0.273
27	0.053	0.118	39	0.072	0.296
28	0.054	0.124	40	0.080	0.321
29	0.054	0.133	41	0.087	0.349
30	0.054	0.146	42	0.098	0.378
31	0.055	0.157	43	0.111	0.410
32	0.056	0.169	44	0.124	0.444
33	0.057	0.182	45	0.139	0.480
34	0.058	0.197	46	0.154	0.517
35	0.059	0.214	47	0.173	0.557
36	0.061	0.232	48	0.186	0.599
37	0.063	0.251	49	0.209	0.647

**The initial premium will not change for the first 10 or 20 years unless the insurance company exercises its right to change premium rates for all insureds under the group policy and with 60 days advance written notice.*

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