ReliaStar Life Insurance Company
A member of the Voya family of companies

Individual Term Life Insurance Application Package

Term Products

California

For your convenience, this Application Package contains 8 forms:

Agent's Checklist:

- ☐ Product, Face Amount and Term Period questions have been completed.
- ☐ Supplemental Rider options have been selected. Refer to the product specs for specific information on rider availability.
- ☐ Required personal information for the Proposed Insured has been completed.
- ☐ Required information for Primary and Contingent Beneficiaries has been completed.
- ☐ Personal History Information section has been fully completed and additional information provided, if applicable.
- ☐ In Force / Replacement Information (Section O) has been thoroughly completed. If any question is marked "Yes," complete all required replacement forms.
- ☐ The STOLI question (Section P) has been completed. The answer given in Section P applies to the Owner. The answer also applies to the Proposed Insured (if different from the Owner).
- ☐ The "City", "State" and "Date" fields have been completed along with appropriate signatures under the Acknowledgements, Certifications, Authorizations and Representations 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.
- ☐ An Authorization for Release of Health-Related Information has been submitted for the Proposed Insured with the application.
- ☐ When applicable, the Credit / Debit Card Authorization and Electronic Funds Transfer form has been completed.
- ☐ Appendices A, D and E have been given to the Proposed Insured, if applicable.
- ☐ Appendices A, B, and E have been given to the Proposed Owner, if applicable.
- ☐ Appendix F has been given to the Payor (if different than the Proposed Owner).
- ☐ A copy of this application has been provided to the Owner and Proposed Insured (if other than the Owner).
- ☐ 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 representation in the Temporary Insurance Receipt (Appendix A) is 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 Insured has attained age 70.

THIS APPLICATION MAY NOT BE USED IF THE POLICY TO BE PURCHASED IS OR MAY BE USED FOR THE BENEFIT OF A THIRD PARTY (A "STRANGER") THAT LACKS AN INSURABLE INTEREST IN THE INSURED. A PERSON GENERALLY HAS AN INSURABLE INTEREST IN THE LIFE OF AN INSURED WHERE THE PERSON HAS A CONTINUED INTEREST IN THE SURVIVAL OF THE INSURED. THE COMPANY DOES NOT ISSUE STRANGER-OWNED / STRANGER-ORIGINATED LIFE INSURANCE TRANSACTIONS ("STOLI") AND WILL SEEK TO VOID ANY SUCH POLICY. YOU AGREE THAT THE COMPANY SHALL RETAIN PREMIUMS PAID AS SPECIAL DAMAGES FOR ANY STOLI POLICY RESCINDED OR FOUND TO BE VOID AND MAY SEEK COSTS AND/OR ADDITIONAL DAMAGES. MATERIAL MISREPRESENTATION REGARDING THE FACTS PRESENTED TO THE COMPANY FOR UNDERWRITING THE APPLICATION OR ATTEMPTS TO DEFRAUD THE COMPANY MAY RESULT IN ADDITIONAL LEGAL ACTION. PLEASE SEE NOTE ABOVE SECTION A AND IN SECTION Q OF THE APPLICATION.

Mail or fax all completed materials to Customer Service

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

Mail overnight to: Customer Service, 2000 21st Ave. NW, Minot, ND 58703

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

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

RESET FORM

INDIVIDUAL TERM LIFE INSURANCE APPLICATION (CA)

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401
A member of the Voya family of companies
(the "Company")

This application may not be used if the policy to be purchased is or may be used for the benefit of a third party (a "stranger") that lacks an insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company does not issue policies for stranger-owned / stranger originated life insurance transactions ("STOLI") and shall seek to void any such policy. You agree that the Company will retain any premiums paid as special damages and may seek recovery of costs and/or additional damages. Material misrepresentation regarding the facts presented to the Company for underwriting the application or attempts to defraud the Company may result in additional legal action. Please see Section Q of the application.

A. PRODUCT INFORMATION *(This application is for use with term products only.)*

1. Product Requested _____ 2. Face Amount $ _____

3. Initial Term Period *(Term period options vary by product.)*:
☐ 10 Year ☐ 15 Year ☐ 20 Year ☐ 25 Year ☐ 30 Year ☐ Other _____

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.)*

☐ Accidental Death Benefit Rider *(Specify amount.)* $ _____
Note: This rider is not the automatic Accelerated Benefit Rider (ABR).

☐ Children's Insurance Rider
(Complete Children's Insurance Rider Application.)

☐ Waiver of Premium Rider
☐ Other _____
☐ Other _____
☐ Other _____

C. PROPOSED INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____
2. Birth Date _____ Birth State / Country _____ Gender: ☐ Male ☐ Female
3. E-mail _____ SSN or Government Issued ID Number _____
4. Daytime Phone (_____)_____ Evening Phone (_____)_____ Best Time to Call _____
5. Residence Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
6. Are you a U.S. Citizen? ☐ Yes ☐ No *(If "No," complete the Foreign Travel and Residence Questionnaire.)*
7. Occupation / Duties _____
8. Employer _____ Employer Phone (_____)_____
9. Employer Address _____ City _____ State _____ ZIP _____
10. Do you currently 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 number, issuer and expiration date.)
13. Name on Driver's License *(if different than above)* _____

D. OWNER *(Questions 1-7 are required when the Proposed Owner is different than the Proposed Insured. Also complete 8-9 if the owner is a corporation, or 10-13 if the owner is a trust.)*

1. Full Name of Owner *(30 character limit)* _____
2. Owner Relationship to Proposed Primary Insured _____ 3. E-mail _____
4. Owner Birth Date _____ Owner Phone (_____)_____ Owner SSN _____
5. Owner Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
6. Billing Address _____ City _____ State _____ ZIP _____

D. OWNER *(Continued)*

7. Type of Government Issued ID *(Driver's License / Passport)* _____ Document Number _____

   Issuing State or Country _____ Issuance Date _____ Expiration Date _____

If the owner is a corporation, complete questions 8-9.

8. Corporation Contact Name _____ TIN _____

9. Corporation Signing Officer Name / Title _____ State of Incorporation _____

If the owner is a trust, complete questions 10-13. Provide a copy of the full Trust document or complete the Trust Certification. *(The Trust must be established prior to the application date.)*

10. Trustee Contact Name _____ TIN _____ Trust Date _____

11. Purpose of the Trust _____ Type of Trust: ☐ Revocable ☐ Irrevocable

12. Trustee/Trustees Name *(List all)* _____ Situs State / State of Incorporation _____

13. Does the trustee (or each trustee if more than one) have sole authority to bind the Trust? ☐ Yes ☐ No *(If "No," state the conditions under which one or more trustees may bind the trust. List the addresses of all trustees on a separate page, and obtain signatures from all trustees on the application.)*

E. SECONDARY ADDRESSEE *(California law allows the applicant to name a secondary addressee to receive notice of lapse or termination of a policy for nonpayment of premium notices.)*

1. First Name _____ MI _____ Last Name _____

2. Address _____ City _____ State _____ ZIP _____

3. Daytime Phone (_____)_____

F. PAYOR *(Complete only if the payor is to be other than the owner.)*

1. Payor Name _____

2. Payor Address *(PO Boxes are not permitted.)* _____

G. BENEFICIARY INFORMATION *(Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)*

Individual as a Beneficiary *(Complete the table below.)*

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

Trust or Business/Corporation as a Beneficiary *(Complete the table below. If the beneficiary is a trust, provide a copy of the full Trust document or complete the Trust Certification.)*

Trust or Business / Corporation Name	Trust Date	Situs State / State of Incorporation	%	Beneficiary Type
				☐ Primary ☐ Contingent
				☐ Primary ☐ Contingent

H. PROPOSED INSURED PERSONAL HISTORY

1. Are you, or have you entered into a written agreement to become, a member of the armed forces, including the Reserves, or on alert? *(If "Yes," complete Military Questionnaire.)* . . . . . ☐ Yes ☐ No

2. Do you intend to travel or reside outside the United States or Canada in the next two years? *(If "Yes," complete Foreign Travel and Residence Questionnaire.)* . . . . . ☐ Yes ☐ No

H. PROPOSED INSURED PERSONAL HISTORY *(Continued)*

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 Aviation Questionnaire.)* . . . . . ☐ 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," to scuba diving, complete Scuba Diving Questionnaire. For all other "Yes," complete Avocations and Professional Sports Questionnaire.)* . . . . . ☐ 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 Motor Sports Questionnaire.)* . . . . . ☐ Yes ☐ No
6. Except for traffic violations, have you been convicted in a criminal proceeding or are you the subject of a pending criminal proceeding? ☐ 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

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

Question	Explanation

I. PAYMENT INFORMATION

1. Initial Payment: ☐ Check with Application[1] ☐ Cash on Delivery ☐ Credit Card[1, 2] ☐ EFT[1, 2]

2. Payment Amount $ _____

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

☐ Military Allotment[4] *(Active or retired military members must complete the Military Allotment form and return it to the military finance department.)*

☐ Civil Service Allotment[4] *(The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)*

[1] *No temporary coverage shall take effect unless a valid Temporary Insurance Receipt is received and all of the conditions stated therein are satisfied.*
[2] *To pay the initial premium by credit card or EFT, complete Appendix F.*
[3] *For your convenience, monthly payments are available with electronic funds transfer; to draft monthly payments, complete Section B of Appendix F.*
[4] *Two full monthly premium payments are required before the policy becomes active.*

J. AUTOMATIC PREMIUM LOAN (APL) *(Available with Endowment Benefit Products only.)*

If you elect the APL Option, you direct the Company to pay premiums due but not paid by the end of the grace period by taking a loan against any available Loan Value. If the available Loan Value is not sufficient to pay the premium then due, the policy may terminate.

☐ I elect the Automatic Premium Loan (APL) Option.

K. FUNDED ERISA INFORMATION *(Complete if the policy will be owned by a "Funded ERISA Plan".)*

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)* _____

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

1. Is the insurance employer-sponsored? ☐ Yes ☐ No List Bill / File Code Number *(if plan already exists)* _____

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

4. Address _____ City _____ State _____ ZIP _____

M. 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.

M. POLICY BACKDATING INFORMATION *(Continued)*

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.

By my signature below, I acknowledge that on backdated policies, 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.**

N. FINANCIAL DETAILS *(Questions 2-6 should be completed by the Proposed Insured and Proposed Owner, if different.)*

1. Do you (the Proposed Owner) believe this proposed life insurance policy will meet your future financial needs and objectives?. . . ☐ Yes ☐ No

Annual figures should be from the last tax year. Total figures should be as of the application date.	Proposed Insured	Proposed Owner
2. Annual Earned Income *(salary, commissions, bonuses, etc.)*	$	$
3. Annual Interest and Other Income *(interest, dividends, pension & rental income, annuity and social security payments, etc.)*	$	$
4. Total Assets *(cash, securities, real estate, cars & personal property, 401K Plans / Pensions Funds, business ownership interests, etc.)*	$	$
5. Total Liabilities *(outstanding debts: mortgages and loans)*	$	$
6. Total Net Worth *(Total Assets minus Total Liabilities)*	$	$

7. Has the Proposed Insured / Proposed Owner or any company owned by either ever declared bankruptcy? *(If "Yes," complete below.)* . . ☐ Yes ☐ No
   a. Bankruptcy filed by _____ b. Chapter Type _____ c. Date Discharged _____

For personal insurance, complete questions 8-11.

8. How much life insurance is in force on the Proposed Insured's spouse / domestic partner that is payable to the Proposed Insured or other dependents? $_____
9. What is the annual income of the Proposed Insured's spouse or domestic partner? $ _____
10. If this application is for a juvenile, indicate the amount of life insurance in force on each parent or sibling.
    Father $ _____ Mother $ _____ Sibling $ _____
11. Purpose of Personal Insurance: ☐ Estate Liquidity ☐ Family Protection ☐ Tax Planning ☐ Retirement Planning ☐ Cash Accumulation ☐ Other _____

For business insurance, complete questions 12-15.

12. Purpose of Business Insurance: ☐ Buy/Sell ☐ Key Person ☐ Other _____
13. Total Business Assets $ _____ Total Business Liabilities $ _____ Total Business Net Worth $ _____
14. Business Net Profit After Taxes for Past Two Years: Last Year $ _____ Previous Year $ _____

15. Business Owner Name *(Executives excluding Proposed Insured)*	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?
		$	%	☐ Yes ☐ No
		$	%	☐ Yes ☐ No

O. IN FORCE / REPLACEMENT INFORMATION *(This section applies to the Owner and the Proposed Insured. Please read each question and if the answer is "Yes" for either the Owner or Proposed Insured, then respond "Yes." If the answer is "No" for both the Owner and Proposed Insured, then respond "No." If a replacement is occurring, the owner of the existing policy is required to terminate the existing policy with a separate written request to the insurance provider.)*

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

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

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.)* . . . . . ☐ Yes ☐ No
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.)* . . . . ☐ Yes ☐ No

O. IN FORCE / REPLACEMENT INFORMATION *(Continued)*

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
			$
			$
			$

P. MEDICAL TRANSFER STATEMENT *(Completed by the proposed insured when submitting medical examinations from another insurance company.)*

1. Insurance Company Name _____ 2. Examination Date _____

3. To the best of your knowledge and belief, are the statements in the above examination true and complete today? . . . . . ☐ Yes ☐ No

4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 2 above? . . . . . ☐ Yes ☐ No

(If "Yes," please provide details below.) _____

_____

Q. VOYA'S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI) *(This section applies to the Proposed Owner and the Proposed Insured, if different.)*

The Company, along with other Voya Life Companies does not issue policies designed to obtain life insurance for the benefit of a third party (a "stranger") that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company shall seek to void any STOLI policy issued.

The Company considers the following arrangements to be fraudulent and does not sell life insurance in the following circumstances:

- If, at the time of sale or conversion, the applicant / owner has an intent, plan, arrangement or understanding with a third party that will result directly or indirectly in the sale, assignment, settlement or other transfer to an investor, such as a life settlement company, or any other party with no insurable interest in the life of the insured who purchases the policy for investment purposes;
- If, at the time of sale or conversion, the applicant / owner has an intent, plan or arrangement to transfer an ownership interest or beneficial interest in an entity that will own the policy to a life settlement company or any other party with no insurable interest in the life of the insured;
- If, in connection with the sale, the applicant / owner and/or the insured is offered any compensation, reward or benefit, or other inducement to purchase or assist in the purchase of the policy, including, but not limited to, cash payments, property such as a life insurance death benefit for "free" or at "no cost" or any other benefit of any kind;
- Where a sales concept, design, marketing plan, marketing material or other program that has not been disclosed to the Company is used in connection with the sale (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending arrangement where the lender's sole collateral for the premium loan is limited to the values of the policy itself);
- Where the producer and/or applicant knows, or has reason to know, that the source of funds for premium payments under a policy has not been disclosed to the Company (including, but not limited to, any arrangement to pay for premiums under the policy through a loan through a premium financing arrangement or other third party funding); or
- In any other circumstance determined by the Company to be STOLI.

The activities described above are considered "prohibited conduct."

To the best of your knowledge and belief, have you engaged in any Prohibited Conduct described in this Section Q in connection with this application for insurance? . . . . . ☐ Yes ☐ No

R. ACKNOWLEDGEMENTS, CERTIFICATIONS, AUTHORIZATIONS AND REPRESENTATIONS

Acknowledgements and Agreement: By signing this application, I acknowledge and agree that:

1. **Application:** I have read this application and I agree with the statements in this application.
2. **Rescission for False Statements:** The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information.
3. **Information Limited to Application.** The application 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.
4. **Company's Liability for Insurance Coverage.** Unless otherwise stated in a valid Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, there is no material change in the health of the Proposed Insured between the time of application and the time of delivery of the policy, and the first premium is received by the Company while the Proposed Insured is alive.
5. **Temporary Insurance.** If I have paid premium by check with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application.
6. **No Waiver by Producer.** The producer does not have the authority 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.
7. **Application Changes.** 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.
8. **Delivery Requirements.** If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force.
9. **Signature.** By signing this application, I am applying for life insurance coverage issued by the Company.
10. **Receipt of Disclosure and Forms.** I received the following disclosures and notices: Accelerated Benefit Rider Disclosure, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding

R. ACKNOWLEDGEMENTS, CERTIFICATIONS, AUTHORIZATIONS AND REPRESENTATIONS *(Continued)*

Collection of Information and Information Practices.

11. **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.
12. **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.

Certification. By signing this application, 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.

Authorizations: By signing this application, I make the following authorizations:

1. **Collection of Medical Record Information or Investigative Reports.** I authorize 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.
2. **Release of Records.** 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 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.
3. **Investigative Consumer Reports.** If an investigative consumer report is prepared, I request to be interviewed. ☐ Yes

   Daytime phone number: (_____)_____.

   Contact me between the hours of _____ a.m./p.m.

   and _____ a.m./p.m.

Representations. By signing this application, I represent that:

1. All questions have been truthfully answered to the best of my knowledge and belief.
2. The policy is not STOLI and I have not engaged in any prohibited conduct as described in Section Q above.
3. The Owner has an insurable interest in the life of the Proposed Insured.
4. I agree to inform the Company of any known material change in health of the Proposed Insured prior to delivery of the Policy.

False or Misleading Information – Criminal and Civil Penalties / Denial of Insurance Benefits: 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.

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Insured Signature *(If age 15 or older)* _____ Date _____

Proposed Owner / Trustee Signature[1] (*If other than the Proposed Insured)* _____ Date _____

Proposed Owner / Trustee Name *(Please print.)* _____

Parent or Guardian Signature _____ Date _____
(If the Proposed Insured is a minor)

[1] *All owners' signatures are required.*

S. AGENT'S REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION

I represent that the policy applied for is not STOLI as described in Section Q, "Voya's Policy on Stranger- Owned or Stranger-Originated Life Insurance (STOLI)." I represent that I am not aware that the applicant is applying for insurance coverage for a stranger as part of a STOLI arrangement and neither I nor the applicant are aware of any information that would notify the Company of the policy's use as STOLI. Neither I nor the applicant have provided any information to the Company contrary to the representations I have made and the applicant has made concerning the policy's use as STOLI. My signature also certifies that except as provided in the answers to the in force replacement questions, the proposed insured(s) / owner(s) do not own any existing life insurance or annuity contracts and no other replacement of insurance or annuity is involved in this transaction. 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.

To the best of my knowledge and belief, all answers provided by the Owner and Proposed Insured in the above application are true, correct and complete.

Writing Agent Signature _____ Date _____

Writing Agent Name *(Please print.)* _____ Writing Agent Number _____

ALL COMPLETED MATERIALS MUST BE SENT TO CUSTOMER SERVICE.

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.*

Sign Here	**Signature** (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	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.

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 650, Denver, CO 80237
(the "Company")

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

Amount Received $ _____

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 (excluding HIV testing unless such test was in connection with an application for insurance)? . . . . . ☐ 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 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.
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Insured Signature *(If age 15 or older)* _____ Date _____

Proposed Owner/Trustee Signature (*If other than the Proposed Insured)* _____ Date _____

Proposed Owner/Trustee Name *(Please print.)* _____

Proposed Other Insured Signature _____ Date _____

Parent or Guardian Signature _____ Date _____
(If the Proposed Insured is a minor)

Writing Agent Name *(Please print.)* _____ Agent Phone (_____)_____

Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE 2ND COPY TO PROPOSED INSURED 3RD COPY TO PROPOSED OWNER

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 650, Denver, CO 80237
(the "Company")

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

Amount Received $ _____

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 (excluding HIV testing unless such test was in connection with an application for insurance)? . . . . . ☐ 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 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.

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- 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.
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Insured Signature *(If age 15 or older)* _____ Date _____

Proposed Owner/Trustee Signature (*If other than the Proposed Insured)* _____ Date _____

Proposed Owner/Trustee Name *(Please print.)* _____

Proposed Other Insured Signature _____ Date _____

Parent or Guardian Signature _____ Date _____
(If the Proposed Insured is a minor)

Writing Agent Name *(Please print.)* _____ Agent Phone (_____)_____

Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE 2ND COPY TO PROPOSED INSURED 3RD COPY TO PROPOSED OWNER

ACCELERATED BENEFIT RIDER DISCLOSURE

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401
A member of the Voya family of companies
Customer Service: PO Box 5011, Minot, ND 58703-5011

READ THE RIDER CAREFULLY

Receipt of an Accelerated Benefit payment may be taxable, and assistance should be sought from a personal tax advisor. Receipt of an Accelerated Benefit payment may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

There is no additional premium required for the Accelerated Benefit Rider; instead, an actuarial discount is associated with the acceleration and an Administrative Expense Charge is assessed upon the exercise of the benefit.

- We will pay an Accelerated Benefit, at the Policy Owner's request, if the Insured has a Qualifying Condition. A Qualifying Condition is a non-correctable medical or physical condition that, with a reasonable degree of medical certainty, will result in the Insured's death in 12 months or less from the date of receipt of a Physician Statement. Refer to the Rider for more details.
- The Policy Owner may request an acceleration of a portion of the Stated Death Benefit, subject to a minimum Accelerated Benefit of $5,000 and a maximum Accelerated Benefit equal to the lesser of 25% of the Stated Death Benefit or $250,000. We will pay the amount requested reduced by:
  - An actuarial discount based on, (1) the annual rate of interest declared by us, and (2) the then current premium;
  - An amount equal to any current Policy loan and accrued loan interest, multiplied by the Benefit Ratio (the Benefit Ratio is equal to the amount accelerated divided by the Stated Death Benefit); and
  - An Administrative Expense Charge of $150.

  The remainder will be paid to the Policy Owner. Other conditions and limitations, as described in the Rider, may apply.
- The Accelerated Benefit will be paid in a lump sum, unless the Policy Owner requests and we agree to payment in some other manner.
- Following an Accelerated Benefit payment, the Policy's Stated Death Benefit, any Cash Value, any outstanding Policy loan, the required premium for the Policy (excluding any policy fee), and premium for any Waiver of Premium Rider (Disability) will all be reduced by the Benefit Ratio. We will mail to the Policy Owner, for attachment to the Policy, an endorsement or amended schedule page that details the changes to the Policy that result from the Accelerated Benefit payment.
- Following an Accelerated Benefit payment, this Rider will terminate. Continued premium payment is required in order to keep the Policy in force.
- If a Waiver of Premium Rider (Disability) is attached to the Policy and in force, and the Insured's Qualifying Condition began before the Policy Anniversary when the Insured reaches age 60, then after an Accelerated Benefit payment the Insured will be deemed to be Totally Disabled for as long as the Physician Statement continues to apply.

An example of the effect of an Accelerated Benefit request of $25,000 is shown below.[1]

Before Acceleration		Requested Acceleration = $25,000		After Acceleration	
Stated Death Benefit	$100,000	Benefit Ratio	25%	Stated Death Benefit	$75,000
Premium	$500	Actuarial Discount[2]	$625	Premium	$375
Policy Loan[3]	$6,000	Loan Repayment[3]	$1,500	Policy Loan[3]	$4,500
Cash Value[3]	$10,000	Administrative Expense Charge	$150	Cash Value[3]	$7,500
		Net Payment to Owner	$22,725		

I acknowledge that I have received and read this summary which has been furnished to me with the Policy/Rider application.

Policy Owner Signature _____ Date _____

Agent/Producer Signature _____ Date _____

[1] *This example is illustrative only and is not intended to show actual values.*
[2] *Assumes hypothetical interest rate of 5%.*
[3] *Cash Value and Policy loans, if any, are only available with the ROP Endowment Term life insurance.*

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? . . . ☐ Yes ☐ No
   a. If "No," explain in Section D.
2. Did you meet with the client in their home? . . . ☐ Yes ☐ No
   a. If "Yes," and the insured is age 65 or older, submit Notice of Life Insurance or Annuity Sales Visit - CA (131550).
3. Is the Proposed Owner applying using the Medi-Cal program? . . . ☐ Yes ☐ No
   a. If "Yes," submit a Notice Regarding Standards for Medi-Cal Eligibility and Recovery (139870).
4. Did you complete the Proposed Insured's Medical Declarations? . . . ☐ Yes ☐ No
   a. If "Yes," did you obtain the Medical Declarations in person and record them in the presence of the Proposed Insured? . . . ☐ Yes ☐ No
   b. If "No," explain in Section D.
5. Was an initial premium payment accepted? . . . ☐ Yes ☐ No
   a. If "Yes," was the Temporary Insurance Receipt completed and delivered to the Proposed Insured or Proposed Owner? . . . ☐ Yes ☐ No
6. Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? . . . ☐ Yes ☐ No
7. Has the Proposed Owner or Proposed Insured previously sold or assigned a policy to a life settlement or viatical company? . . . ☐ Yes ☐ No
   a. If "Yes," provide details. _____
8. 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

This authorization is HIPAA compliant.

PROPOSED INSURED INFORMATION

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

Birth Date _____ SSN/TIN _____

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).*

Authorized Life Insurance Carrier(s) _____

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 hereby authorize the release of any and all records and information regarding me, the proposed insured, according to the terms of this authorization. This includes any and all 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 Agent/Agency 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.

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 Agent/Agency 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 Agent/Agency.

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 Agent/Agency named above at the following address.

Attention: Privacy Official

Agency Address _____

City _____ State _____ ZIP _____

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/PROPOSED OTHER INSURED.

CONSUMER NOTICES

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.

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)

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

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.

THIS PAGE MUST BE GIVEN TO THE PROPOSED INSURED AND PROPOSED OWNER.

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

VALUABLE INFORMATION ABOUT YOUR TERM LIFE INSURANCE PURCHASE

Thank you for considering the Company for your life insurance needs. Your professional insurance producer may work with many life insurance companies, and we are pleased that your producer has presented one of our products to you.

We'd like you to understand how we pay the selling producer. Producers earn a commission for each policy sold. The commission is generally a percentage of the policy premiums you pay. The percentage may be higher for producers that sell a larger number of policies. Producers may receive additional compensation for each year a policy remains in force or for achieving certain sales volume levels. The actual percentage and amount of compensation paid will vary based on the specific circumstances of your purchase.

Producers may receive additional non-cash compensation from us as a reward for things like achieving sales contest objectives or other measures. We also may pay for producer education, training or attendance at conventions, and may provide financing, or other payments or benefits. In addition, some producers may be associated with independent marketing organizations ("IMOs") that have agreements with us. IMOs provide administrative services to independent producers and marketing support for our policies. We may make payments to IMOs that may be based on the amount of premium written with us by producers associated with the IMO.

This is a general discussion of the compensation we pay for the sale of our policies. We pay commissions and other sales expenses from our general assets and revenues, including amounts we earn from fees and charges under our policies. We set the price of an insurance policy and it reflects the compensation we pay for the sale of the policies. It also covers costs we incur for the design, manufacture and service of our policies, for policy benefits and features including guarantees, and for the investment management needed to support the policies' values. We and our affiliates offer other insurance products in addition to the product you have selected. These other products may have different features, benefits, fees and charges and may provide you coverage that could meet your needs at a greater or lesser cost to you. We are committed to providing top-quality insurance products to our customers and are pleased that your professional insurance producer trusts us to deliver on your long-term insurance needs.

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

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

THIS PAGE MUST BE GIVEN TO THE PROPOSED INSURED AND PROPOSED OWNER.

CREDIT / DEBIT CARD PAYMENT AUTHORIZATION AND ELECTRONIC FUNDS TRANSFER

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401
(the "Company")
A member of the Voya family of companies
Customer Service, 2000 21st Ave. NW, Minot, ND 58703

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.

IMPORTANT NOTICE: If initial payment is made by Credit/Debit Card or Electronic Funds Transfer, no temporary coverage shall take effect unless a valid Temporary Insurance Receipt is received and all of the conditions stated therein are satisfied.

A. CREDIT/DEBIT CARD PAYMENT AUTHORIZATION *(This is available for all Term Products except in New York.)*

Request and Authorization for Credit/Debit Card Payment of Initial Premium: The Company is hereby requested and authorized to initiate a credit/debit card transaction to be charged against the account described in the Authorization below for the ***initial payment only***. Subsequent premium payments will be made either by direct billing or EFT.

☐ I would like to pay my initial payment by credit or debit card.

Insured Name *(Please print.)*	Policy Number	Payment Amount

Full Name *(Print as it appears on card.)* _____

Account Number *(16 digits)* _____ Expiration Date *(month and year)* _____

Billing Zip Code _____ Credit/Debit Card Type: ☐ MasterCard ☐ Visa ☐ Discover

If I have not submitted a valid Temporary Insurance Receipt, I am not requesting temporary coverage before my policy coverage begins.

I authorize the Company to charge my initial insurance premium for the policy numbers listed above, to the credit/debit card account I have indicated. I understand that this payment will be for the initial premium only, and that I will either be billed for subsequent payments directly or by EFT.

Cardholder Signature[1] _____ Date _____

[1]*Payment cannot be processed without signature.*

B. ELECTRONIC FUNDS TRANSFER

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.

B. ELECTRONIC FUNDS TRANSFER *(Continued)*

Please Note: Premiums paid more frequently than annually result in higher total premiums for the same coverage.

☐ I would like to pay my initial premium by EFT. ☐ I would like to pay my subsequent premiums by EFT.

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

Payment Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually *(Frequency other then monthly depends on the policy type.)*

Insured Name *(Please print.)*	Policy Number	Deduction
		$
		$
		$
		$

Request Specific Draft Date for Recurring Payments[2] *(Between the 1st and the 28th)* _____

Bank Name _____ Account Type: ☐ Checking ☐ Savings

Bank Address _____

City _____ State _____ ZIP _____

Name(s) on Account _____

SSN/TIN _____ Phone (_____) _____

[2] *Depending on the type of policy you own, the draft date options may vary. Please call us at 877-882-5050 option 1, option 1 for more information.*

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

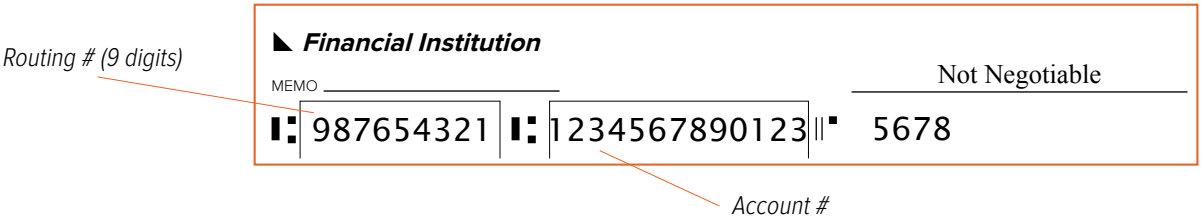
Tape voided check here.

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

If I have not submitted a valid Temporary Insurance Receipt, I am not requesting temporary coverage before my policy coverage begins.

Account Owner Signature _____ Date _____

Sample Check



RESET FORM

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD, URINE OR OTHER BODILY FLUID TESTING (CA)

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ Security Life of Denver Insurance Company, Denver, CO
Customer Service: PO Box 5075, Minot, ND 58702-5075

☐ ReliaStar Life Insurance Company, Minneapolis, MN
Employee Benefits: PO Box 20, Mail Stop 4-S, Minneapolis, MN 55440

A member of the Voya family of companies

Examiner Address _____

City _____ State _____ ZIP _____

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, urine or other bodily fluid for testing and analysis to determine, the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result.

DESCRIPTION AND PURPOSE OF TESTS TO BE PERFORMED

A series of three tests will be performed by a licensed laboratory on your blood, urine or other bodily fluid sample in accordance with medical protocols required by the California Insurance Code to determine whether you may have been infected with the HIV virus. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

1. The laboratory will perform initial Elisa blood, urine or other bodily fluid test.
2. If the initial Elisa test is positive, then a repeat Elisa blood, urine or other bodily fluid test will be performed.
3. If the second Elisa test is positive, a Western Blot test will be conducted to confirm the positive Elisa test results. If any of the three tests yield negative results, the tests will not be used for underwriting purposes.

If you have a positive Elisa test followed by a reactive Western Blot Assay performed on the same specimen, your life insurance application will be declined.

POTENTIAL USES

If your HIV test results are positive, the company will report a "nonspecific abnormality" of your blood, urine or other bodily fluid test to MIB, Inc. (MIB). MIB contains the names and computerized medical records of insurance applicants nationally. The report will not identify you has having an abnormal HIV antibody test because many other blood, urine and other bodily fluid test abnormalities are reported to the Bureau under the same classification.

LIMITATIONS

An HIV test is considered positive only when conducted according to the protocol specified by the California Insurance Code. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

a. False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test results to develop after a person is infected.

MEANING OF THE TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. If your blood, urine or other bodily fluid is tested for HIV antibodies and if your test results are positive, the company will notify the physician designated below to whom you have authorized disclosure and with whom you may discuss the results. Positive HIV antibody test results will adversely affect your insurance application.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. Test results will be reported to the company. The results may be reported to ING affiliates, reinsurers, or contractors in connection with insurance you have or have applied for. In addition, if our HIV antibody test is positive, a generic code signifying a nonspecific blood, urine or other bodily fluid test abnormality will be reported to MIB as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

ORIGINAL TO COMPANY COPY TO PROPOSED INSURED

CONFIDENTIALITY OF TEST RESULTS

Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application.

NOTIFICATION OF TEST RESULT

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results means, you are asked to list your private physician so that the Insurer can have him or her tell you the test results and explain its meaning.

Name of physician for reporting a possible test result _____

Address _____

City _____ State _____ ZIP _____

Phone (_____)_____

If you do not wish to know the results of the test, initial here: ____. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer will require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: ____. The result will be sent to you at the address provided by registered mail with delivery restricted to you only.

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Blood, Urine or Other Bodily Fluid Testing. I voluntarily consent to the withdrawal of blood from me, a sample of urine given by me, or an oral swab, and the testing of that blood, urine or other bodily fluid, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This authorization expires thirty months from the date it is signed.

Proposed Insured Name *(Please print.)* _____

Proposed Insured or Parent/Guardian Signature _____ Date _____

Address _____

City _____ State _____ ZIP _____

ORIGINAL TO COMPANY COPY TO PROPOSED INSURED

LATEST FACTS ABOUT AIDS

If Your Test For Antibody to the AIDS Virus Is Positive [1]

The virus [2] that causes AIDS (acquired immune deficiency syndrome) may have infected as many as 1 to 1-1/2 million Americans.

Many people who are infected with the virus have not developed any symptoms, while others have had relatively minor illnesses. The most serious form of illness caused by the virus is AIDS, which involves loss of the body's natural immune defenses against disease.

The AIDS virus is primarily spread by sexual contact and by sharing of contaminated needles and syringes among users of intravenous drugs. The virus can also be transmitted from infected mothers to their babies during pregnancy, at birth, or shortly after birth (probably through breast milk). In a small number of cases, the virus has been spread through blood transfusions and through blood products used to treat patients with hemophilia and other blood clotting disorders.

THE AIDS ANTIBODY TEST

Antibodies are substances produced in the blood to fight disease organisms. When antibodies to a specific organism are found in a person's blood, they indicate that the person has been infected by that particular organism.

Since spring 1985, a test for antibody to the AIDS virus has been used by blood collection centers to keep donated blood and plasma that might carry the virus from becoming part of the nation's blood supply. The antibody test is also available — through private physicians and at clinics in most states— to people who may want to know their antibody status. Those considered to be at risk of infection include men who have had sex with another man since 1977; people who inject illegal drugs, or who have done so in the past; people with symptoms that suggest AIDS virus infection; people from Haiti and Central African countries, where heterosexual transmission seems to be more common than in this country; male or female prostitutes and their sex partners; sex partners of persons who are infected or are at increased risk of infection; people with hemophilia who have been treated with clotting factor products; and infants of high-risk or infected mothers.

WHAT DOES A POSITIVE ANTIBODY TEST MEAN?

If your test for AIDS antibody is positive, it usually means that you have been infected by the virus. Occasionally, however, a person may have a positive test result even though he or she has never been exposed to the AIDS virus. This is called a "false positive" reaction. To be sure that the test result is truly positive, the test is repeated, and in some cases a different type of laboratory test may also be performed.

A positive test result does not mean that you will get AIDS — many people with a positive test either remain free of symptoms or develop less serious illnesses. The antibody test cannot tell you whether you will eventually develop signs of illness related to AIDS virus infection — or, if you do, how serious that illness might be.

A positive test result does indicate that you have been infected by the AIDS virus and most probably can transmit it to others, even if you show no symptoms. It's likely that you will carry the virus in your body throughout your life.

HOW CAN I PROTECT MY HEALTH?

After getting the results of your test, you should see a doctor for a checkup and follow-up care. Your doctor will want to discuss your situation with you thoroughly, answer your questions, make sure that you receive the counseling you need, and check you at regular intervals to help you maintain your health.

HOW CAN I PROTECT OTHERS?

To protect others from getting the virus from you, there are some important steps you should take:

- Be sure to tell your sex partners about your positive test result. Avoiding sex would eliminate any risk of spreading the virus by sexual means; however, if you and your partner decide to go ahead, be careful to protect him or her from contact with your body fluids, which may carry the AIDS virus. ("Body fluids" includes blood, semen, urine, feces, saliva, and vaginal secretions.) Use a condom, which will help reduce the chances of spreading the virus, and avoid practices, such as anal intercourse, that may injure body tissues and make it easier for the virus to enter the bloodstream. Oral-genital contact should also be avoided, as should open-mouthed, intimate kissing.
- People who have been your sex partners may have been exposed to the AIDS virus. If you have used intravenous drugs, anyone you have shared needles and syringes with may have been exposed too. You should tell these persons about your positive test result and urge them to seek counseling and antibody testing from a doctor or health clinic.
- Don't share toothbrushes, razors, tweezers, or other items that could become contaminated with blood.
- If you use drugs, consider enrolling in a drug treatment program to help protect your health. Remember that needles and other drug equipment must never be shared.

HOW CAN I PROTECT OTHERS? *(Continued)*

- Don't donate blood or plasma, body organs, other body tissue, or sperm.
- Clean spills of blood or other body fluids on household or other surfaces with freshly diluted household bleach — one part bleach to 10 parts water. (Don't use bleach on wounds.)
- When you seek medical help, tell the doctor, dentist, eye doctor, or other health worker who gives you care about your positive AIDS antibody test, so that steps can be taken to protect you and others.
- If you are a woman with a positive test result, consider avoiding pregnancy until more is known about the risks of transmitting the AIDS virus to your baby. If you do become pregnant, it's important to see a doctor for regular care during your pregnancy. Because the AIDS virus has been found in breast milk, you should not breastfeed your baby.

WHAT ABOUT THE ORDINARY ACTIVITIES OF MY DAILY LIFE?

You should be careful to follow the normal practices everyone needs to maintain good health: Eat a well-balanced diet, exercise, rest, and try to manage your life in a way that avoids undue stress. But there's no reason to change your activities in ways beyond those that have already been discussed. Your positive test status should not affect your contacts with people at work or in social situations. Special precautions are not necessary: The AIDS virus is not spread by ordinary nonsexual contact such as shaking hands, sharing an office, coughing or sneezing, preparing or serving food, or sharing toilet facilities.

Your relationships with family members and friends should continue to be close and supportive. Hugging, kissing on the cheek, and other forms of affectionate behavior that don't involve exchange of body fluids do not spread the AIDS virus.

It should be stressed that scientists have not found a single instance in which the AIDS virus has been transmitted through ordinary nonsexual contact in a family, work, or social setting.

A FINAL WORD

The news that you have had a positive result on your AIDS antibody test is not easy to receive. For your follow-up care, it's best to establish a close relationship with a doctor you trust, so that you can speak openly about your feelings, problems, and any fears you may have. Above all, ask questions — and seek assurance from any health professional who takes care of you that all information related to your health will be kept in the strictest confidence.

The U.S. Public Health Service has made AIDS and other AIDS virus-related illnesses its number one priority. Scientists all over the country are working to find ways to eliminate the AIDS virus as a threat to health. A great deal of research progress has been made — and made quickly — and there is every reason to expect these advances to continue at an even faster pace.

More information about AIDS and AIDS-related illnesses can be obtained from —

- Your doctor.
- Your state or local health department.
- The Public Health Service's toll-free hotline:

  1-800-342-AIDS.
- Your local chapter of the American Red Cross.

If you would like information about drug treatment programs, call the toll-free hotline of the National Institute on Drug Abuse: 1-800-662-HELP.

[1] Article reprinted with permission of the author. American Red Cross.

[2] The virus that causes AIDS and related disorders has several different names: HTLV-III, LAV, ARV, and most recently HIV. In this article it is called "the AIDS virus."

RESET FORM

CALIFORNIA REGULATION Ins s 789.8 DISCLOSURE

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

☐ Voya Insurance and Annuity Company, Des Moines, IA
Customer Service: PO Box 617, Des Moines, IA 50303-0617

☐ Voya Retirement Insurance and Annuity Company, Windsor, CT
PO Box 990063, Hartford, CT 06199-0063

A member of the Voya family of companies

California applicants who are age 65 or older at the time of solicitation must sign and submit this disclosure with the application.

The sale or liquidation of any asset in order to buy insurance, either life insurance or an annuity contract, may have tax consequences. Terminating any life insurance policy or annuity contract may have early withdrawal penalties or other costs or penalties, as well as tax consequences.

You may wish to consult independent legal or financial advice before the sale or liquidation of any asset, stock, bond, IRA, certificate of deposit, mutual fund, life insurance policy, annuity contract or other asset.

Applicant Name _____

Applicant Signature _____ Date _____

Owner Signature
(if other than Applicant) _____ Date _____

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NOTICE REGARDING REPLACEMENT (CA)

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ Security Life of Denver Insurance Company, Denver, CO
Customer Service: 2000 21st Ave. NW, Minot, ND 58703
Phone: 877-882-5050

VOYA FINANCIAL™

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant Name *(please print)* _____

Applicant Signature _____ Date _____

Producer Name *(please print)* _____

Producer Signature _____ Date _____

1st Copy: Applicant 2nd Copy: Insurer 3rd Copy: Producer

Order #166983 **CA** 09/01/2014
TM: NBAPP

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

FOR DISTRIBUTION BY INSURERS, AGENTS AND BROKERS

ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO
Customer Service: PO Box 5075, Minot, ND 58702-5075

Voya Insurance and Annuity Company, Des Moines, IA
Customer Service: 909 Locust Street, Des Moines, IA 50309-2899

A member of the Voya family of companies

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal Program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

MARRIED RESIDENT

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $109,560 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $2,739 in monthly income, whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $111,560 in countable resources. The order also may allow the at-home spouse to retain more than $2,739 in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Order #139870 09/01/2014

REAL PROPERTY EXEMPTIONS

One principal residence. One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

Real property used in a business or trade. Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

IRAs, KEOGHs, and other work-related pension plans. These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

Personal property used in a trade or business.

One motor vehicle.

Irrevocable burial trusts or irrevocable prepaid burial contracts.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

SIGNATURES

I have read the above notice and have received a copy.

Purchaser Signature _____ Date _____

Spouse Signature _____ Date _____

Legal Representative Signature _____ Date _____

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CREDIT / DEBIT CARD PAYMENT AUTHORIZATION

ReliaStar Life Insurance Company, Minneapolis, MN
("the Company")
A member of the Voya family of companies
Customer Service, PO Box 5052, Minot, ND 58702-5052

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. No temporary coverage shall take effect unless a valid Temporary Insurance Receipt is received and all of the conditions stated therein are satisfied.

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION

(This is available for all Term Products except in Maryland, New York and North Carolina[1] and is available for Universal Life Products ONLY in the states of CA and AK.)

Request and Authorization for Credit/Debit Card Payment of Initial Premium: The Company is hereby requested and authorized to initiate a credit/debit card transaction to be charged against the account described in the Authorization below for the ***initial payment only***. Subsequent premium payments will be made either by direct billing or EFT.

Insured Name *(please print)*	Policy Number	Payment Amount

Premium Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Full Name *(Print as it appears on card.)* _____

Account Number *(16 digits)* _____ Expiration Date *(month and year)* _____

Billing Zip Code _____ Credit/Debit Card Type: ☐ MasterCard ☐ Visa ☐ Discover

I authorize the Company to charge my initial insurance premium for the policy numbers listed above, to the credit/debit card account I have indicated. I understand that this payment will be for the initial premium only, and that I will either be billed for subsequent payments directly or by EFT.

Cardholder Signature[2] _____ Date _____

[1] *In NC only debit cards are allowed to be used. Credit card usage is prohibited.*
[2] *Payment cannot be processed without signature.*

Order #152529 09/01/2014