

Life Insurance Evidence of Insurability Form

■ Type or print clearly in ink.
 ■ Return to ReliaStar Life Insurance Company.

SECTION 1: EMPLOYEE

Social Security or Employer I. D. Number	Last Name	First Name	Middle Initial	Agency/Division
House Number	Street Address	Apt./Unit Number	Phone: Work () Home ()	Birth Date (MO/DAY/YR) <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	ZIP Code + 4	Do you or any family member you are requesting coverage for smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete and sign Nonsmoker Certification section in the life insurance enrollment form or change form.	

SECTION 2: EMPLOYEE: Evidence of insurability (To be completed only when applying for Part C or Part D more than 60 days after insurance eligibility date, OR when applying for more than \$50,000 Part D within 60 days of eligibility date.)

Employee Name _____ Height _____ Weight _____ Sex _____
 Occupation _____ Birth Date _____ Birthplace _____ Marriage/Qualified Domestic Partnership Date _____

Provide details for any "Yes" answers below. Use a separate sheet if necessary.

- | | | |
|--|---|---|
| 1. Have you had any injury, sickness, or ailment, or have you consulted or been treated by a health care provider for any reason in the past five years?

<input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Have you ever had:
A. High Blood Pressure, Heart Disease, or Arteriosclerosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Mental Illness, Stroke, or Epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Cancer, Diabetes, or Nephritis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
D. Any problems with the back or spine?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
E. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Are you now unable to work full time because of any disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you take regular medication for treatment or control of any condition or ailment?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you contemplate any operation or visit to a doctor for an existing injury or ailment?.. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|---|

Condition/Illness/Injury	Type of Treatment	Date of Treatment	Names and Addresses of Health Care Providers Consulted

SECTION 3: SPOUSE/QUALIFIED DOMESTIC PARTNER: Evidence of insurability (To be completed only when applying for Part B Basic or Part B Supplemental Spouse Life more than 60 days after insurance eligibility date, OR when applying for more than \$25,000 Part B Supplemental Spouse Life within 60 days of insurance eligibility date.)

Are you a state employee? Yes No
 If yes, are you also applying for coverage through your agency? Yes No

NOTE: The employee will always be designated as beneficiary for spouse/qualified domestic partner and dependent life insurance.

Spouse/Qualified Domestic Partner Name _____ Height _____ Weight _____ Sex _____
 Occupation _____ Birth Date _____ Birthplace _____ Marriage/Qualified Domestic Partnership Date _____

Provide details for any "Yes" answers below. Use a separate sheet if necessary.

- | | | |
|--|---|---|
| 1. Have you had any injury, sickness, or ailment, or have you consulted or been treated by a health care provider for any reason in the past five years?

<input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Have you ever had:
A. High Blood Pressure, Heart Disease, or Arteriosclerosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Mental Illness, Stroke, or Epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Cancer, Diabetes, or Nephritis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
D. Any problems with the back or spine?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
E. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Are you now unable to work full time because of any disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you take regular medication for treatment or control of any condition or ailment?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you contemplate any operation or visit to a doctor for an existing injury or ailment?.. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|---|

Condition/Illness/Injury	Type of Treatment	Date of Treatment	Names and Addresses of Health Care Providers Consulted

Authorization:

By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

For any medical provider, facility, insurance company, Medical Information Bureau (MIB) Inc., or employer: I give my permission for you to give ReliaStar Life or its authorized representatives ALL INFORMATION on my behalf except as stated below. This can include findings on medical care or any non-medical information that applies to me, my spouse, or my qualified domestic partner. I also permit ReliaStar Life to get investigative or consumer reports about the same people.

I declare that I have read ReliaStar Life's Insurance Information Practices Notice on the back of this form. I allow ReliaStar to disclose this information to its affiliates (including consumer reporting agencies and MIB, Inc.) to verify my/our insurability. I know that my/our medical records may be protected by federal regulations—42CFR Part 2.

I can cancel this authorization at any time, as it applies to information protected by these federal regulations, but not after ReliaStar Life or its affiliates has taken action based on this information.

I understand that my additional written consent will be required before any information above is given, sold, transferred, or in any way relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

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

I allow my employer to deduct money from my earnings to pay for any optional insurance I requested and approved by ReliaStar Life Insurance Company. This form replaces all previous forms and submissions I have made for PEBB life insurance.

Date	Employee's Signature <i>(required)</i>		
Date	Spouse/Qualified Domestic Partner's Signature <i>(if applying)</i>	Spouse/Qualified Domestic Partner's Social Security Number <i>(if applying)</i>	

Mail completed form to:

ReliaStar Life Insurance Co., P.O. Box 20, Route 7325, Minneapolis, MN 55440-0020
 HCA 50-645D (11/07)

For Agency Use
Date sent to carrier: _____

ReliaStar Life Insurance Company

Insurance Information Practices Notice

We are pleased to provide you with information regarding this Evidence Form. This information is provided to you in accordance with legislation enacted in your state.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Evidence Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your Evidence Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See “Notice Regarding MIB, Inc.” below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with ReliaStar Life or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.