APPLICATION FOR LIFE INSURANCE

FIXED AND VARIABLE PRODUCTS

INSTRUCTIONS TO AGENTS AND APPLICANTS

- **CONDITIONAL RECEIPT.** A Receipt must be given to the Applicant/Owner if a premium payment is made. A copy must be sent to the Administrative Office. No agent has the authority to alter the provisions of the Conditional Receipt.

  Premium cannot be collected with the application if the face amount applied for exceeds $4,500,000 or if the total amount in force and currently applied for exceeds (1) $10,000,000 through age 68; or (2) $5,000,000 if the Proposed Insured is age 69 or older.

  Additional state limitations may be added upon notification by ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company").

  Applicant/Owner should understand all provisions of the Conditional Receipt.
- Check appropriate Company box on page 1 of the application.
- If you are applying for more than one product, provide details in Section 6 of the Agent's Report on page 7.
- Be sure to complete fully the signature box on page 6.
- If special requirements need to be considered, be sure to submit a **COVER LETTER** with all details.
- Please print all responses on this application in black ink.
- The word "You" refers to the proposed insured or proposed owner.
- Do not make checks payable to agent or leave payee blank.

NOTICE TO APPLICANTS REGARDING POLICY DATING PROCEDURES

Policy Date Information and General Dating Practices

Your policy will be issued with a policy date. This date is important because it governs many of the duties and obligations under this policy. Premiums are billed from the policy date. Renewal premiums are due as of the anniversary of the policy date. Your policy will be dated either on the date that it is issued or on a date that you specifically request. Within certain limits, you may choose a date that is before the date of your application or a date that is after your application.

There are a number of reasons why you might request a specific policy date, such as:

- To obtain a lower premium if a date before the date of issue would result in a lower insurance age.
- To obtain a savings in premium by selecting a future policy date, since premiums are billed from the policy date.
- To coincide with other elements of an estate plan.
- To provide a preselected convenient date as the due date for premiums.

Right to request change in policy date

For applicants who choose to pay no premium until the policy is delivered or who are required to pay additional premium upon delivery only: If you decide at the time of policy delivery that you would like to change the date of your policy to the delivery date, you may choose to do so. The Policy Delivery Receipt included with your policy will contain instructions for changing the policy date to the delivery date.

Please note that your request to change the policy date to be the date of delivery may result in an increase in your premium as a result of a change in insurance age. If so, you will be notified by the Company and you may then decide not to have the policy redated.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE FOLLOWING ING COMPANY:

☐ **ReliaStar Life Insurance Company,**

or

☐ **Security Life of Denver Insurance Company**

ELECTRONIC FUNDS TRANSFER (EFT)

Request and Authorization Agreement for Pre-Arranged Payments or Electronic Bank Debit Plan for Payment of Premiums. ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company") is hereby requested and authorized to draw checks or initiate bank debits to be charged against the account described in the Authorization below.

Please X one of the boxes below:
- ☐ Start new EFT Plan
- ☐ Add to existing EFT Plan No. ____________
- ☐ Change existing bank name or Accounting No.

Policy Number	Proposed Insured's Name *(First/Middle Initial/Last)*	Monthly Deduction

I request the day of withdrawals or debits to my account to be on or about the ________ of each month. *(Any day from the 1st through the 28th of the month may be selected.)*

Bank Account Information and Type *(Please check one box: Either Checking or Savings)*

Check company(ies):

☐ ReliaStar Life Insurance Company

☐ Security Life of Denver Insurance Company

Staple voided check here
-NOT Deposit Slip-

☐ Checking ☐ Savings

Banking Account Number

Transit Routing Number (9 digits)

Name of Bank or Credit Union

Street

City | State | Zip

Terms of the EFT Plan

Each debit will be: (1) in an amount sufficient to pay a proper proportion of the annual premium at the Company's EFT premium rate; (2) notice of premium due and no further notice of premium will be given; (3) a receipt for the amount stated thereon if and when the Company receives actual payment. If a debit is not honored by the bank upon presentation for payment by the Company, such action by the bank will be notice of nonpayment of premium.

The EFT Plan for premium payment may be terminated by the Policyowner or by the Bank Depositor/premium payor by written notice filed with the Company and may be terminated by the bank in which the account is maintained. The Company also may terminate without notice if any debit is not honored upon presentation, otherwise upon 30 days written notice to the Policyowner. In the event the Plan is terminated for any cause, any unpaid premiums, and premiums which have due dates that occur on or after the date of termination, will be paid directly to the Company at the premium rate and on the premium due date which would have been applicable to each policy if it had not been placed under the EFT Plan for premium payment. If the Company is not paid within the time required by the policies, the said policies will lapse and have no further value, except as otherwise provided in said policies.

The Company may, at its discretion from time to time, effect payments by use of prearranged payments (debit) or an electronic bank debit system.

It is agreed that:

- This authorization will apply to any conversion, renewal or change made in said policies.
- The Company encourages the Policyowner to obtain overdraft protection from its bank to avoid any unhonored withdrawals and associated fees.
- The Company may increase the premium withdrawal amount sufficient to maintain insurance coverage. Such increase would occur 30 days after providing written notification of the increase.

Authorization Agreement for Prearranged Payments (Debits)

I (we) authorize ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company") to make variable charges to my (our) checking or savings account identified above, and authorize the financial institution named above to withdraw funds from (debit) such account and pay to the Company's order accordingly. This authorization will remain in effect until the financial institution has received and has had reasonable time to act on a written request from me (us) to terminate this agreement.

I have read and understand the above statement:

Signature of Bank Account Owner	Social Security/Tax I.D. Number	Date Signed
Signature of Bank Account Owner	Social Security/Tax I.D. Number	Date Signed

CONSUMER PRIVACY NOTICE

NOTICE REGARDING CONSUMER REPORTS

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, we will send you the name, address and telephone number of any agency we ask to prepare a consumer report about you. You can ask that the agency interview you if you so state 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; by contacting you, members of your family, business associates and employers, financial sources, friends or others you know. This information will not be used to determine your sexual orientation. 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 ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company"). You may request that this information not be communicated to other companies affiliated with the Company.

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 (MEDICAL INFORMATION BUREAU, INC.)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested.

MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask MIB, it will arrange to disclose to you the information it has in your file. If you question the accuracy of the information in MIB's file, you may contact MIB to seek correction, as provided in the Federal Fair Credit Reporting Act. The address of MIB's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112. MIB's phone number is (617) 426-3660.

We or our reinsurers may also release information in our files. We may release it 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 upon request.

NOTICE REGARDING INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. 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.

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

Individual Life Underwriting
ReliaStar Life Insurance Company
20 Washington Avenue South
Minneapolis, MN 55401-1908

or

Individual Life Underwriting
Security Life of Denver Insurance Company
1290 Broadway
Denver, CO 80203-5699

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NOTICE:

For Applicants in all States except for Colorado, Connecticut, District of Columbia, Kentucky, Louisiana, Ohio and Tennessee.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files an application, statement or claim containing false, incomplete or misleading information may be guilty of insurance fraud.

THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THESE NOTICES:

COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance or civil damages. Any insurance company or its agent who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

CONNECTICUT:

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files an application, statement or claim containing any false, incomplete, or misleading information may be guilty of insurance fraud as determined by a court of competent jurisdiction.

DISTRICT OF COLUMBIA:

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

KENTUCKY AND OHIO:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

LOUISIANA:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

LIFE INSURANCE APPLICATION

Agent ID# ____________

Initial Product Solicited: ____________	Issued by: ☐ **ReliaStar Life Insurance Company** ☐ **Security Life of Denver Insurance Company**

☐ Check here if insurance is for a tax-qualified, pension, or ERISA covered welfare benefit plan and complete Section 5 in the Agent's Report.
Employer sponsored? ☐ Yes ☐ No

Section A. Proposed Primary Insured Information

1. Name *(First, MI, Last)*			**2.** Social Security Number	**3.** Driver's License Number	State
4. Date of Birth	**5.** Sex ☐M ☐F	**6.** Place of Birth	**7.** Telephone Number ( )	**8.** Annual Earned Income $	
9. Residence Street Address	City	State	Zip Code	**10.** Occupation/duties	
11. Employer					

12. Do you currently use or have you ever used tobacco or nicotine products in any form, e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum or nicotine patches? ☐ Yes ☐ No If yes, type ____________ daily amount ________ month/year last used ________
Type ____________ daily amount ________ month/year last used ________

Section B. Proposed Other Insured (Joint Insured or Additional Insured)

1. Name *(First, MI, Last)*			**2.** Social Security Number	**3.** Driver's License Number	State
4. Date of Birth	**5.** Sex ☐M ☐F	**6.** Place of Birth	**7.** Telephone Number ( )	**8.** Annual Earned Income $	
9. Residence Street Address	City	State	Zip Code	**10.** Occupation/duties	
11. Employer			**12.** Relationship to Proposed Insured		

13. Do you currently use or have you ever used tobacco or nicotine products in any form, e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum or nicotine patches? ☐ Yes ☐ No If yes, type ____________ daily amount ________ month/year last used ________
Type ____________ daily amount ________ month/year last used ________

Section C. Proposed Owner Information

Complete if the Owner is other than the Proposed Primary Insured. If the Proposed Primary Insured is a minor, always specify the Owner.

1. Owner Name if other than Proposed Primary Insured or Name of Trust and Trustee		**2.** Relationship to Proposed Primary Insured	
3. Date of Trust	**4.** Date of Birth	**5.** Social Security Number or Tax ID Number	
6. Residence Street Address	City	State	Zip Code
7. Address for Premium Notice if Other than Residence	City	State	Zip Code

Section D. Medical Transfer Statement

Complete when submitting medical examinations of another insurance company.

		Proposed Insured		Proposed Other Insured	
1.	Name of the insurance company for which examination(s) was made and date of examination:	Yes	No	Yes	No
2.	To the best of your knowledge and belief, are the statements in the examination true and complete today?	☐	☐	☐	☐
3.	Have you consulted a medical doctor or other practitioner since the above examination? *(If yes, see Section L)*	☐	☐	☐	☐

Section E. Base Policy Information

Must attach a copy of the illustration signed by the applicant.

1. Base Face Amount *(Not including Term Riders)*	2. Mode of Payment	3. Planned/Scheduled Premium
$		

4. Product Type ☐ Fixed ☐ Variable – *(Owner must receive a current prospectus, and investment feature selection form must be completed if applying for a variable life insurance policy.* **THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER CERTAIN CONDITIONS, AND THE CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNTS.***)*

5. Death Benefit Option: ☐ A or 1-Level ☐ B or 2-Increasing or Variable ☐ C or 3 – Face Amount + Premium

6. Death Benefit Qualification Test: ☐ Guideline Premium Test ☐ Cash Value Accumulation Test

7. Rate Class Quoted: ☐ No Tobacco ☐ Alternate Tobacco *(cigars, pipes, chewing tobacco, nicotine gum or patch)*
☐ Tobacco (cigarettes) ☐ Other ______________________

Section F. Rider Information. Illustration required for permanent products.

Check appropriate box and enter amounts. (NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS.)

1. Riders:

- ☐ Accelerated Benefit Rider
- ☐ Waiver of Premium (Term)
- ☐ Waiver of Monthly Deduction or Cost of Insurance Rider
- ☐ Waiver of Specified Premium Rider ....$________
  (Specify monthly premium – illustration required)
- ☐ Additional Insured Rider *(on Primary Insured)* ....$________
- ☐ Additional Insured Rider *(on Additional Insured)*..$________
- ☐ Accidental Death Benefit Rider.........................$________
- ☐ Children's Insurance Rider ....$ ________
  (Complete supplement)
- ☐ Extension of Rate Guarantee Rider..........$ ________
- ☐ Term Rider *(Specify)* ....$ ________
  ____
- ☐ Adjustable Term Insurance Rider ....$ ________
  (Specify Target Death Benefit)
  ____
- ☐ Future Purchase Option Rider..........$ ________
- ☐ Other ______________ ....$ ________
- ☐ Other ______________ ....$ ________

2. Special Dating Request: ☐ Date to save age ☐ Specific date *Month* ________ *Day* ________ *Year* ________

Section G. Suitability (Complete for Variable Products only)

1. Have you, the proposed owner, received a current prospectus including supplements for the variable life insurance policy and each of the Variable Account Investment Options? ☐ Yes ☐ No

   The policy prospectus/supplement is dated ______________________

2. **Do you understand that the amount or duration of the policy death benefit may vary under specified conditions: that policy values may increase or decrease in accordance with the investment experience of the investment options; that they may also increase in accordance with the interest credited in the Guaranteed Interest Division; and that the amount payable at the final policy date is not guaranteed, but is dependent on the account value and amounts owed under the policy at that time?** ☐ Yes ☐ No

3. Do you understand that the fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in a down market? ☐ Yes ☐ No

4. Do you understand that personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience or of actual interest credited in the Guaranteed Interest Division? ☐ Yes ☐ No

5. With this in mind, is the policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No

6. Do you believe you have the financial ability to continue making premium payments on this policy? ☐ Yes ☐ No

Section H. Beneficiary Information for Proposed Primary and Joint Insureds

Unless otherwise stated, the beneficiary designation is revocable and beneficiaries of like class shall share equally with right of survivorship.

1. *If Trust, provide name and date of trust agreement. If Corporation, provide state of incorporation.*

a. Primary Beneficiary(ies) *(Print full names and addresses)*	Relationship to Proposed Insured	Birthdate	Social Security Number/ Tax ID	%
b. Contingent Beneficiary(ies) *(Print full names and addresses)*	Relationship to Proposed Insured	Birthdate	Social Security Number/ Tax ID	%

Section I. Beneficiary Information for Proposed Other Insured or Additional Insured Rider

Unless otherwise stated, the beneficiary designation is revocable and beneficiaries of like class shall share equally with right of survivorship.

1. *If Trust, provide name and date of trust agreement. If Corporation, provide state of incorporation.*

a. Primary or Base Additional Insured Rider Beneficiary *(Print full names and addresses)*	Relationship to Proposed Insured	Birthdate	Social Security Number/ Tax ID	%
b. Contingent or Joint Additional Insured Rider Beneficiary *(Print full names and addresses)*	Relationship to Proposed Insured	Birthdate	Social Security Number/ Tax ID	%

Section J. Financial Information

1. Personal Finances: Check box(es) to indicate purpose of insurance.

☐ Estate Liquidity ☐ Family Protection ☐ Loan Protection ☐ Tax Planning ☐ Retirement Planning ☐ Cash Accumulation ☐ Other________

a. Annual Interest & Other Income	b. Total Assets	c. Total Liabilities	d. Total Net Worth

2. Business Finances ***(Complete question #2 only if this is business insurance.)***

☐ Key Employee ☐ Buy/Sell ☐ Creditor ☐ Employee Benefits (Split Dollar, Deferred Compensation, etc.) ☐ Other________

a. Total Assets	b. Total Liabilities	c. Net Worth	d. Net Profit After Taxes for Past Two Years: *Last Year*	*Previous Year*

e. Name of Owner(s)	Title	Percentage of Ownership	Active in Business *(yes or no)*	Amount of Business Coverage in Force

f. Is other insurance being applied for concurrently on Proposed Insured or other officers? ☐ Yes ☐ No *If yes, complete the following:*

Insurance Company Name	Amount	Officer or Proposed Insured

Section K. General Information for Application for Life Insurance

Complete the following on all Proposed Insureds, including children to be covered under the Children's Insurance Rider.

1. Life Insurance In Force ☐ Yes ☐ No *(If yes complete the following.)*

Proposed Insured's Name	Company	Personal Life Benefit	Business Life Benefit	Accidental Life Benefit	Date Issued

	Proposed Insured Yes	Proposed Insured No	Proposed Other Insured Yes	Proposed Other Insured No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If yes, complete state required replacement form.)*	☐	☐	☐	☐
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.)*	☐	☐	☐	☐

Proposed Insured's Name	Company	Policy Number	Amount

	Yes	No	Yes	No
4. Is this insurance intended to be a tax free exchange – 1035 Exchange? *(1035 not available on term rider)*	☐	☐	☐	☐
5. If yes, will a policy loan be carried over?	☐	☐	☐	☐
6. Will the applicant accept this policy if it is a "Modified Endowment Contract" at issue?	☐	☐	☐	☐
7. Do you have any other applications for life insurance pending?	☐	☐	☐	☐
8. If yes, will all applications now pending for life insurance be accepted and placed in force?	☐	☐	☐	☐

9. List company(ies) and amount(s) of coverage applied for

Proposed Insured's Name	Company	Amount Applied For

	Yes	No	Yes	No
10. Have you in the last 12 months had any known or suspected heart attack, stroke, or cancer, or been treated by any physician or other practitioner for any of these conditions?	☐	☐	☐	☐
11. Have you in the last 60 days been advised by any physician or other practitioner to have any diagnostic test or surgery not yet performed?	☐	☐	☐	☐
12. Have you in the last 10 years been diagnosed or treated for positive HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immunodeficiency Syndrome)?	☐	☐	☐	☐
13. 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?	☐	☐	☐	☐
14. Except for traffic violations, have you been convicted in a criminal proceeding or been the subject of a pending criminal proceeding?	☐	☐	☐	☐

15. Provide the details for all yes answers to questions 10-14.

Proposed Insured's Name	Question #	Details

	Yes	No	Yes	No
16. Are you a member, or do you intend to become a member of the armed forces, including the Reserves or on alert? *(If yes, complete Military Questionnaire)*	☐	☐	☐	☐
17. Are you a US citizen? *(If no, complete the Foreign Travel and Residence Questionnaire)*	☐	☐	☐	☐
18. Do you intend to change your residence or travel outside the United States or Canada? *(If yes, complete the Foreign Travel and Residence Questionnaire)*	☐	☐	☐	☐
19. Have you in the last five years made or do you anticipate making flights in an aircraft OTHER than as a passenger on a scheduled airline? *(If yes, complete the Aviation Questionnaire)*	☐	☐	☐	☐
20. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, rodeos, or any other hazardous sports or activities? *(If yes, complete appropriate questionnaire)*	☐	☐	☐	☐
21. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes, dune buggies, etc.? *(If yes, complete motorized vehicle/powerboat questionnaire)*	☐	☐	☐	☐

Section L. Declarations of the Proposed Insureds for Application for Life Insurance

Personal Physicians (*If none, state none.*)	a. Name, address and phone number of Physician	b. Date, reason and results of last consultation
1. Primary Insured		
2. Other Proposed Insured		

3. Name	Height/Weight	Weight change in last year

Question	Proposed Insured Yes	Proposed Insured No	Proposed Other Insured Yes	Proposed Other Insured No	Record the question number, person, condition; diagnosis and dates/duration of condition or treatment; name and address of all doctors and hospitals
4. In the past 10 years, have you ever been treated for or been diagnosed by a licensed member of the medical profession as having:					
a. Dizziness, fainting, convulsions, optic neuritis, headache, paralysis, stroke, mental or nervous disorder?	☐	☐	☐	☐	
b. Shortness of breath, persistent hoarseness or cough, spitting of blood, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐	☐	☐	☐	
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐	☐	☐	
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, diverticulitis, or other disorder of the stomach, intestine, liver or gall bladder?	☐	☐	☐	☐	
e. Sugar, albumin, blood or pus in urine, venereal disease, nephritis, stone, or other disorder of kidney, bladder, breasts, prostate or reproductive organs?	☐	☐	☐	☐	
f. Diabetes, thyroid or other endocrine disorder?	☐	☐	☐	☐	
g. Rheumatism, arthritis, or disorder of the muscles or bones?	☐	☐	☐	☐	
h. Disorder of skin, lymph glands, cyst, tumor or cancer?	☐	☐	☐	☐	
i. Allergies, anemia or other disorder of the blood?	☐	☐	☐	☐	
5. Have you:					
a. Experienced any symptom(s) for which you have not yet consulted a health care provider?	☐	☐	☐	☐	
b. Had any operation(s) in the past 10 years?	☐	☐	☐	☐	
c. Been advised to have operation(s) or diagnostic tests not yet performed in the last 10 years?	☐	☐	☐	☐	
d. Had an electrocardiogram, x-ray, or other diagnostic test in the last five years?	☐	☐	☐	☐	
e. Sought or been advised to seek help or treatment for an alcoholic habit? If yes, complete Alcohol Usage Questionnaire.	☐	☐	☐	☐	
f. In the last 10 years been confined for observation, care, or treatment in a hospital or other health care facility?	☐	☐	☐	☐	
g. In the last five years consulted any health care provider(s) not already identified for any reason including routine physical examination?	☐	☐	☐	☐	
6. Are you:					
a. Presently taking any medication(s), including non-prescription/over the counter medication or presently under the care of a member of the medical profession for any condition?	☐	☐	☐	☐	
b. Currently using, or have you ever received treatment or counseling for the use of: ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, opium derivatives, or other drugs of abuse? If yes, complete Drug Use Questionnaire.	☐	☐	☐	☐	

7. Family history of Proposed/Other Insured:	*Age if living*		*Age at death*		*Current health or cause of death*	
	Proposed	*Other*	*Proposed*	*Other*	*Proposed*	*Other*
Father						
Mother						
Brothers						
Sisters						

Section M. Authorization and Acknowledgement

By completing this life insurance application, I understand that I am applying for life insurance coverage which may be issued by one or more of the ING life companies, which include ReliaStar Life Insurance Company and Security Life of Denver Insurance Company, referred to individually or collectively as the "Company." I understand and consent that this application and information obtained pursuant to this authorization may be used by the Company to evaluate my eligibility for life insurance. For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, clinic or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), any consumer reporting agency, or any other organization to release to the Company or their authorized representatives (including any consumer reporting agency) acting on their behalf ALL INFORMATION requested by the Company about me and any minor children who are to be insured. This includes but is not limited to: (a) any medical information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and treatment of me or my minor children who are to be insured; (b) prescription drug records and related information maintained by physicians, pharmacy benefit managers and other sources; and (c) any non-medical information about me or my minor children who are to be insured. By this authorization, each physician, medical practitioner, hospital, clinic or medically related facility contacted by the Company is instructed to provide the entire medical record in its possession concerning me or any minor children who are to be insured.

I give my permission to the Company to get consumer or investigative consumer reports about these same persons.

I give my permission to the Company and other insurance companies affiliated with the Company to get any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. I may revoke this permission and authorization as it applies to any information protected by 42CFR Part 2 or by applicable state law at any time by mailing the written revocation to the Company at the address on the Consumer Privacy Notice page, but not to the extent action has been taken in reliance on it. I understand that the release of medical records will not be requested with respect to tests performed to determine the presence of the human immunodeficiency virus (HIV) antibody.

In connection with any application for life insurance or other insurance transaction that I may have with the Company, I specifically consent that some or all of the information obtained by this authorization may be sent to MIB, reinsurers, the agent who solicited my application and his principals, employees or contractors who process transactions regarding any insurance coverage I may have applied for or have with the Company or affiliated companies. I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy.

- I understand that I may request to be interviewed if an investigative consumer report is prepared.
  You may contact me between the hours of ______ and ______. My telephone number is (   ) ____________________.
- I know that I have a right to get a copy of this form. A photocopy of this form will be as valid as the original.
- This form will be valid for 24 months from the date shown below.
- I acknowledge receipt of the following notices: Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.

Each of the undersigned also declares that:

A. I have read the statements and answers given in this application and affirm that they are true and complete to the best of my knowledge and belief and also correctly recorded.

B. (1) This application consists of Sections A through L, supplemental questionnaires, and medical exam and will be the basis for any policy issued on this application; (2) Any policy issued on this application will not take effect unless the first full premium is paid and the policy is delivered to the Owner of such policy during the lifetime and continued insurability, as stated in the application, of the person(s) to be covered by such policy, except as otherwise provided in the Conditional Receipt, if issued, with the same date as this application; (3) Except where permitted expressly by statute or regulation, no agent or medical examiner has the authority to waive the answer to any question in the application, to pass on insurability, to make or alter any contract or waive any of the Company's rights or requirements; (4) No change in the amount, classification, age at issue, plan of insurance or benefits on this application shall be effective unless agreed to in writing by the proposed insured and owner.

C. I certify, under penalty of perjury, that my social security/tax identification number(s) is shown and is correct and that I am not subject to back up withholding.

Automatic Telephone Privileges – Variable Products Only

I acknowledge that my policy automatically will provide telephone privileges to perform certain transactions as specified in the current prospectus to me as policy owner and to my agent/registered representative and the registered representative's assistant. I also agree that the Company and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be authentic. The Company may employ procedures that might include requiring forms of personal identification before accepting such telephone instructions. I understand that if I do not want myself or my agent/registered representative and the registered representative's assistant to have such telephone privileges, I must indicate so below. I also understand that once granted, such privilege can be revoked only upon receipt of signed written instructions at the Company.

☐ I do not want telephone privileges.

☐ I do not want telephone privileges granted to my agent/registered representative and the registered representative's assistant.

Signed by Owner at *(City, State)*		Signature of Agent/Registered Rep. X		
Signature of Proposed Insured if age 15 or older X	Date	Agent ID #	Agent State Lic. #	Registered Rep. #
Signature of Proposed Other Insured X			Date	
Signature of Proposed Owner if other than the Proposed Insured X			Date	
Signature of Parent or Guardian if the Proposed Owner or the Proposed Primary Insured is a minor X				

AGENT'S REPORT

Section 1. *To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.*

Agent Name/Broker Dealer	Agent ID #	% Split	Hierarchy Pointer ID	Hierarchy Pointer Name

Section 2. Premium Information

Initial Payment	☐ Check	☐ COD ☐ 1035 Exchange	☐ Home Office Credit		☐ Conversion
Age Used in Calculating Premium	Initial Payment	Requested Modal Payment	Amount Collected	Annualized Planned Periodic Premium	Amount Received by Administrative Office
	$	$	$	$	$ *(To be completed by Home Office.)*

Mode of Payment

☐ Annually ☐ Semi-Annually
☐ Quarterly ☐ Monthly *(Complete EFT Form.)*
☐ Other ______

☐ Government/Military Allotment *(Complete allotment form.)*
☐ Payroll Deduction/List Bill *(Enter Special Collect Number if plan already exists.)* ______

Section 3. Compliance Information

1. Did you obtain the Proposed Insured's Declarations in this application in person and record them in the presence of the Proposed Insured? *(If not, arrange for exam)*.......... ☐ Yes ☐ No
2. Have you delivered the Notice Regarding Consumer Reports, the Notice Regarding MIB Inc., and the Notice Regarding Information Practices to the Proposed Insured(s) or Proposed Owner?.......... ☐ Yes ☐ No
3. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? *(If yes, submit applicable state replacement forms)* .... ☐ Yes ☐ No
4. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Insured or Proposed Owner? .. ☐ Yes ☐ No

Section 4. Insured Information

1. How long have you known the Proposed Insured?______ Are you related? ☐ Yes ☐ No If yes, how?______
2. How much insurance does the Proposed Insured's spouse own payable to the Proposed Insured or other dependents? $ ______
3. If this application is on a juvenile, please indicate the amount of life insurance in force on each parent or sibling.
   Father $______ Mother $______ Siblings $______
4. a. Did you use a fact finder or needs analysis tool in connection with this sale?.......... ☐ Yes ☐ No
   b. If yes, which one(s)? ______
5. Please check the medical requirements ordered: ☐ Paramedical Exam ☐ HOS ☐ Blood Profile ☐ Inspection ☐ Stress EKG ☐ EKG ☐ MD Exam ☐ Paramed Company______
6. Does the proposed insured speak English? .... ☐ Yes ☐ No
   a. If no, were the application and all solicitation materials interpreted for and understood by the proposed insured and owner? . ☐ Yes ☐ No
   b. If no, will the policy form be interpreted for the proposed owner? .... ☐ Yes ☐ No

Section 5. Funded ERISA Plan Information

If the policy will be owned by a "Funded ERISA Plan", you must specify the plan and trust type by checking the appropriate box below and provide the other information indicated.

☐ Tax-qualified plan *(specify, i.e. 401(a), profit sharing, defined benefit, defined contribution, and HR10)*: ______
☐ Section 419/419A plan *(specify trust name)*: ______
☐ VEBA Trust *(specify trust name)*: ______
☐ Secular Trust

Section 6. Remarks *(Use this area to request alternates/optionals, including the selection of alternative commission structures where available.)*

______
______
______

Section 7. Agent's Signature Section

Agent's Signature(s)		Date	Contact for Requirements
Telephone	Fax number	Email address	

If premium is collected, detach this receipt and give to client.

CONDITIONAL RECEIPT

Check the company to which premium is being paid:
- ☐ ReliaStar Life Insurance Company, Minneapolis, MN
- ☐ Security Life of Denver Insurance Company, Denver, CO

Administrative Office for all companies:
ING Service Center
2000 21st Avenue NW
Minot, ND 58703

IF WITHIN THE LAST YEAR, THE PROPOSED INSURED HAS RECEIVED ANY TREATMENT OR ADVICE FROM A PHYSICIAN FOR TUMOR OR CANCER OR ANY BRAIN, HEART, LUNG OR KIDNEY DISORDER, A CONDITIONAL RECEIPT MAY NOT BE GIVEN AND PREMIUM MAY NOT BE COLLECTED.

Received from

____

the sum of

____

in payment of the first full modal premium for an insurance policy applied for on the life of

____

Proposed Insured, for which this application as dated below has been made to ReliaStar Life Insurance Company and/or Security Life of Denver Insurance Company (the "Company").

This Conditional Receipt does not create temporary or interim insurance and it does not provide any coverage except as provided herein.

I. REPRESENTATIONS — Applicable to each Proposed Insured named above

	Yes	No
1. Has the Proposed Insured(s):		
a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which the Proposed Insured(s) has not consulted a physician?	☐	☐
b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?	☐	☐
c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the immune system?	☐	☐
d. attained age 70?	☐	☐
2. For each Proposed Insured, is the initial amount of life insurance applied for on all applications pending with the Company plus the current amount of all existing life insurance with the Company more than $4,500,000?	☐	☐
3. For each Proposed Insured, does existing life insurance with all insurers plus amount applied for in pending application(s) with all insurers exceed $10,000,000?	☐	☐

(For #2 and #3 amount of insurance calculations, include all policies, term riders, and accidental death coverage and second to die coverage for each Proposed Insured.)

If any of the above questions are answered YES or LEFT BLANK, the agent is not authorized to accept a premium, and there will be NO COVERAGE. There also will be no coverage under this receipt if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. 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 if issued as applied for under the Application; or (b) $4,500,000. 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 conditional receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed $4,500,000; and the $4,500,000 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

Premium(s) will be returned if no policy is delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium.

All the above representations are true and complete to the best of my knowledge and belief. I agree that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way.

DATE COVERAGE BEGINS

Coverage under this receipt starts when: Sections A through K are completed; a premium has been accepted; and this form has been completed and signed.

DATE COVERAGE ENDS

This coverage will end automatically on the **earliest** of the date:

- Five days after a refund of premium is mailed to the Owner's address shown on the application.
- Five days after a notice of termination is mailed to the owner's address shown on the application.
- Coverage starts under any policy resulting from the Application.
- A policy resulting from the Application is refused.
- 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.

NO COVERAGE

There is no insurance coverage if:

- There is a material misrepresentation in the answers to the questions above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. **(This suicide clause does not apply in the state of Missouri)**
- The premium check or authorized withdrawal is not honored.

____

Proposed Insured/Owner Signature

____

Signed at City/State

____

Licensed Agent Signature *Date*

____

Print Agent Name

____

Agent Telephone Number

If premium is collected, detach this receipt and keep for your records.

CONDITIONAL RECEIPT

Check the company to which premium is being paid:

☐ ReliaStar Life Insurance Company, Minneapolis, MN

☐ Security Life of Denver Insurance Company, Denver, CO

Administrative Office for all companies:
ING Service Center
2000 21st Avenue NW
Minot, ND 58703

IF WITHIN THE LAST YEAR, THE PROPOSED INSURED HAS RECEIVED ANY TREATMENT OR ADVICE FROM A PHYSICIAN FOR TUMOR OR CANCER OR ANY BRAIN, HEART, LUNG OR KIDNEY DISORDER, A CONDITIONAL RECEIPT MAY NOT BE GIVEN AND PREMIUM MAY NOT BE COLLECTED.

Received from

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the sum of

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in payment of the first full modal premium for an insurance policy applied for on the life of

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This Conditional Receipt does not create temporary or interim insurance and it does not provide any coverage except as provided herein.

I. REPRESENTATIONS — Applicable to each Proposed Insured named above

	Yes	No
1. Has the Proposed Insured(s):		
a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which the Proposed Insured(s) has not consulted a physician?	☐	☐
b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?	☐	☐
c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the immune system?	☐	☐
d. attained age 70?	☐	☐
2. For each Proposed Insured, is the initial amount of life insurance applied for on all applications pending with the Company plus the current amount of all existing life insurance with the Company more than $4,500,000?	☐	☐
3. For each Proposed Insured, does existing life insurance with all insurers plus amount applied for in pending application(s) with all insurers exceed $10,000,000?	☐	☐

(For #2 and #3 amount of insurance calculations, include all policies, term riders, and accidental death coverage and second to die coverage for each Proposed Insured.)

If any of the above questions are answered YES or LEFT BLANK, the agent is not authorized to accept a premium, and there will be NO COVERAGE. There also will be no coverage under this receipt if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

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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 if issued as applied for under the Application; or (b) $4,500,000. 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 conditional receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed $4,500,000; and the $4,500,000 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

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All the above representations are true and complete to the best of my knowledge and belief. I agree that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way.

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- Five days after a notice of termination is mailed to the owner's address shown on the application.
- Coverage starts under any policy resulting from the Application.
- A policy resulting from the Application is refused.
- 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.

NO COVERAGE

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- There is a material misrepresentation in the answers to the questions above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. **(This suicide clause does not apply in the state of Missouri)**
- The premium check or authorized withdrawal is not honored.

____

Proposed Insured/Owner Signature

____

Signed at City/State

____

Licensed Agent Signature *Date*

____

Print Agent Name

____

Agent Telephone Number

If premium is collected, send in with the application.

CONDITIONAL RECEIPT

Check the company to which premium is being paid:
☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ Security Life of Denver Insurance Company, Denver, CO

Administrative Office for all companies:
ING Service Center
2000 21st Avenue NW
Minot, ND 58703

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This Conditional Receipt does not create temporary or interim insurance and it does not provide any coverage except as provided herein.

I. REPRESENTATIONS — Applicable to each Proposed Insured named above

	Yes	No
1. Has the Proposed Insured(s):		
a. in the past 10 years had unintentional weight loss, or any symptoms of a disease or an impairment for which the Proposed Insured(s) has not consulted a physician?	☐	☐
b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?	☐	☐
c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the immune system?	☐	☐
d. attained age 70?	☐	☐
2. For each Proposed Insured, is the initial amount of life insurance applied for on all applications pending with the Company plus the current amount of all existing life insurance with the Company more than $4,500,000?	☐	☐
3. For each Proposed Insured, does existing life insurance with all insurers plus amount applied for in pending application(s) with all insurers exceed $10,000,000?	☐	☐

(For #2 and #3 amount of insurance calculations, include all policies, term riders, and accidental death coverage and second to die coverage for each Proposed Insured.)

If any of the above questions are answered YES or LEFT BLANK, the agent is not authorized to accept a premium, and there will be NO COVERAGE. There also will be no coverage under this receipt if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

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GENERAL

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All the above representations are true and complete to the best of my knowledge and belief. I agree that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way.

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- Five days after a notice of termination is mailed to the owner's address shown on the application.
- Coverage starts under any policy resulting from the Application.
- A policy resulting from the Application is refused.
- 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.

NO COVERAGE

There is no insurance coverage if:

- There is a material misrepresentation in the answers to the questions above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. **(This suicide clause does not apply in the state of Missouri)**
- The premium check or authorized withdrawal is not honored.

____
Proposed Insured/Owner Signature

____
Signed at City/State

____
Licensed Agent Signature *Date*

____
Print Agent Name

____
Agent Telephone Number

Authorization for Release of Health-Related Information to:
ReliaStar Life Insurance Company,
Security Life of Denver Insurance Company,
ReliaStar Life Insurance Company of New York,
ING USA Annuity and Life Insurance Company of Iowa, and
Midwestern United Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

Administrative Office:
2000 21st Ave., NW
Minot, ND 58703

Name of Proposed Insured/Patient (please print)

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the "the Company" and its agents, employees, and representatives. 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 and 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.

This protected health information is to be disclosed under this Authorization so that "the Company" may: 1) underwrite my application for coverage, 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 Company".

This authorization shall remain in force for 30 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 Company", Attention: Privacy Official. 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 Company" 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.

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 Company" 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.

Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

ING Service Center
2000 21st Avenue, NW
Minot, ND 58703

☐ ReliaStar Life Insurance Company
☐ Security Life of Denver Insurance Company
☐ Southland Life Insurance Company

Consent to Blood (and Other Body Fluids) Testing
Disclosure Authorization

I give my consent to the above named insurer, its employees, contractors, affiliated companies and reinsurers, to conduct the following:

(1) Blood (and/or other body fluids) test for antibodies to the AIDS virus (HIV); if I reside in a state which permits insurers to conduct this test; and

(2) Such other or additional tests which the company may lawfully order.

My consent to this testing is freely given, based on the following understandings:

(1) The purpose of the test(s) is to determine whether I am insurable for life insurance.

(2) I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood (and/or other body fluids) tested and by refusing to give sample(s). I know that if I do not take the test(s), my application to the company for life insurance will be declined.

(3) The test(s) for the antibodies to the AIDS virus (HIV) will be conducted following approved test protocols.

(4) If state law permits, I will be notified of positive HIV test results. Otherwise, I will be asked to designate, in writing, the name and address of the physician to whom I want the test results sent. I understand that in some states positive results may only be disclosed to the physician I designate to receive the results.

I further understand that test results will not be released or disclosed to any party (other than the company and related parties identified above, to whom I hereby authorize disclosure) unless:

(a) I expressly authorize their release in writing; or
(b) A public health reporting law requires disclosure; or
(c) A court order requires disclosure.

I understand that disclosures under 4(b) and 4(c) may be made without my consent.

(5) I understand that the company may report to the Medical Information Bureau (MIB) any abnormal blood (and/or other body fluids) test, but the company will not disclose the type of blood (and/or other body fluids) test which was abnormal. I acknowledge receipt of the company's Notice Regarding the MIB, Inc.

I know that I have the right to get a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO TESTING AND DISCLOSURE AUTHORIZATION.

Name of Proposed Insured	Signature of Proposed Insured
State of Residence of Proposed Insured	Date
Name of Examiner	Signature of Examiner

☐ ReliaStar Life Insurance Company
☐ Southland Life Insurance Company
☐ Security Life of Denver Insurance Company
(check one)

Administrative Office for all companies:

ING Service Center
2000 21st Avenue NW
Minot, ND 58703

ACKNOWLEDGEMENT IN LIEU OF ILLUSTRATION SUBMISSION

For use when no illustration is used during solicitation, when the policy applied for is different than as shown in the illustration used during solicitation or when a computer screen was used during solicitation.

Definition of Illustration: An illustration is any written or computer information that depicts the non-guaranteed values of a life insurance policy over a period of time greater than one year. For example, a document that shows non-guaranteed values as of age 65 would be an illustration.

I. **Applicant**: I acknowledge that: (please select one)

☐ No illustration was used in this solicitation

☐ The illustration(s) used in this solicitation did not conform to the policy applied for

☐ A computer screen was used in this solicitation and the information described below was displayed.

INFORMATION DISPLAYED ON COMPUTER SCREEN

Name of insured: ______________________ Name of insured: ______________________

Age: __________ Gender: __________ Underwriting Classification: ______________________

Generic name of policy: ______________________

Company product name: ______________________ Form #: __________

Generic name of rider(s): ______________________

Guaranteed interest rate: __________ Non-guaranteed interest rate: __________

Number of policy years illustrated: __________ Initial death benefit: __________

Premium amount illustrated is $__________ which is payable __________ (mode) for __________ (assumed number of years premiums will be paid)

Name of insurer: ______________________

Name and address of agent: ______________________

I understand that an illustration conforming to any policy issued in connection with this application will be provided to me on or before delivery of the policy.

Applicant signature ______________________ Date __________

Applicant signature ______________________ Date __________

II. **Agent**: I certify that:(please select one)

☐ No illustration was used in the solicitation of this application for insurance.

☐ The illustration(s) used in this solicitation did not conform to the policy applied for.

☐ A computer screen was displayed in this solicitation and that the information described above was displayed.

I have explained that any non-guaranteed elements of the policy are subject to change. I have made statements on non-guaranteed elements that are wholly consistent with the illustration that will be provided to the applicant at policy delivery.

Agent signature ______________________ Date __________

Agent number ______________________

128364 (10/03)

ReliaStar Life Insurance Company
P.O. Box 20 • Minneapolis, MN 55440
Administrative Office
P.O. Box 5050 • Minot, ND 58702-5050

NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY.
THIS NOTICE IS FOR YOUR BENEFIT AND IS REQUIRED BY LAW

1. If you are urged to purchase life insurance and to surrender, lapse, or in any other way change the status of existing life insurance, the agent is required to give you this notice.

2. It may not be advantageous to drop or change existing life insurance in favor of new life insurance, whether issued by the same or a different insurance company. Some of the disadvantages are:

   a. The amount of the annual premium under an existing policy may be lower than that under a new policy having the same or similar benefits.

   b. Generally, the initial costs of life insurance policies are charged against the cash value increases in the earlier policy years, the replacement of an old policy could result in the policyholder sustaining the burden of these costs twice.

   c. The incontestable and suicide clauses begin anew in a new policy. This could result in a claim under a new policy being denied by the company which would have been paid under the old policy.

   d. Existing policies may have favorable provisions than new policies in such areas as settlement options and disability benefits.

   e. An existing policy may have a reserve value in addition to any cash value which may be of some benefit to the insured.

   f. The insurance company carrying your current insurance policy can often make a desired change on terms which would be more favorable than if existing insurance is replaced with new insurance.

3. It may not be advantageous to change an existing policy to reduced paid-up or extended term insurance or to borrow against its loan value beyond your expected ability or intention to repay in order to obtain funds for premiums on a new policy.

4. There may be a situation in which a replacement policy is advantageous. You may want to receive the comments of the present insurance company before deciding this important financial matter.

I hereby acknowledge that I received the above "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" before I signed the application for the proposed new insurance.

______________________ Date

______________________ Signature of Applicant

Definitions

Premiums: Premiums are the payments you make on the life insurance or annuity contract. They are unlike deposits in a savings or investment program because if you drop the policy you might get back less than you paid in.

Cash Surrender Value: This is the amount of money you can get if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

Lapse: A life insurance policy may lapse when you do not pay the premiums within the grace period. If your policy had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

Surrender: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. If a policy has a cash surrender value, you can receive such value in cash if you return the policy to the company with a written request.

Place on Extended Term: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before but you will only be covered for a specified period of time.

Borrow Policy Loan Values: If your life insurance policy has a cash surrender value, you can usually borrow all or part of said amount from the insurer. Interest will be charged according to the terms of the policy, and if the loan and unpaid interest ever exceeds the cash surrender value the policy will be terminated. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

Evidence of Insurability: This means proof that you are an acceptable risk. You have to meet the standards of the insurer regarding age, health, occupation, and such other standards as the insurer feels necessary to be eligible for coverage.

Incontestable Clause: This says that after one (1) or two (2) years, according to the provisions of the contract, the insurer shall not resist a claim because you made a false or incomplete statement when you applied for the policy. During the first two years if there are false or incomplete answers on the application and the insurer discovers them, the insurer can deny a claim as if the policy has never existed.

Suicide Clause: This says that if you commit suicide after being insured for less than two years, your beneficiaries will receive only a refund of the premiums that were paid.

ReliaStar Life Insurance Company
P.O. Box 20 • Minneapolis, MN 55440
Administrative Office
ING Minot Service Center
P.O. Box 5050 • Minot, ND 58702-5050

STATEMENT BY APPLICANT REGARDING NOTIFICATION OF REPLACEMENT TO THE REPLACED INSURER

I have read the "NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY" which was furnished to me by the agent taking the application for this policy. (Applicant: Please sign one of the following statements.)

1. Please notify my present insurer(s) regarding this transaction.

____________________ ____________________
Date Signature of Applicant

2. Please do not notify my present insurer(s) regarding this transaction.

____________________ ____________________
Date Signature of Applicant

The signature of the applicant shall be that of the insured unless someone other than the insured is the owner of the policy. If someone other than the insured is the owner of the policy, the owner must sign. If the insured is under eighteen (18) years of age, the parent is deemed to be the owner of the policy.

Certification by the agent:

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

____________________ ____________________
Date Signature of Agent

____
Insurance Agency or Agent License Number

Definitions

Premiums: Premiums are the payments you make on the life insurance or annuity contract. They are unlike deposits in a savings or investment program because if you drop the policy you might get back less than you paid in.

Cash Surrender Value: This is the amount of money you can get if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

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Surrender: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. If a policy has a cash surrender value, you can receive such value in cash if you return the policy to the company with a written request.

Place on Extended Term: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before but you will only be covered for a specified period of time.

Borrow Policy Loan Values: If your life insurance policy has a cash surrender value, you can usually borrow all or part of said amount from the insurer. Interest will be charged according to the terms of the policy, and if the loan and unpaid interest ever exceeds the cash surrender value the policy will be terminated. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

Evidence of Insurability: This means proof that you are an acceptable risk. You have to meet the standards of the insurer regarding age, health, occupation, and such other standards as the insurer feels necessary to be eligible for coverage.

Incontestable Clause: This says that after one (1) or two (2) years, according to the provisions of the contract, the insurer shall not resist a claim because you made a false or incomplete statement when you applied for the policy. During the first two years if there are false or incomplete answers on the application and the insurer discovers them, the insurer can deny a claim as if the policy has never existed.

Suicide Clause: This says that if you commit suicide after being insured for less than two years, your beneficiaries will receive only a refund of the premiums that were paid.

Agreement For The Exchange of Insurance & Absolute Assignment Policies under Section 1035 of the Internal Revenue Code

Check one company.

☐ ReliaStar Life Insurance Company, Minneapolis, MN
☐ Security Life of Denver Insurance Company, Denver, CO
☐ Southland Life Insurance Company, Plano, TX

Administrative Office for all companies:
ING Service Center
2000 21st Ave. NW
Minot, ND 58703

I. TYPE OF EXCHANGE.

☐ Life Insurance for Life Insurance ☐ Life Insurance For Annuity ☐ Endowment for Annuity ☐ Annuity for Annuity

Has an irrevocable beneficiary been name for any policy or contract listed above?.. ☐ Yes ☐ No

Is any policy or contract listed subject to a Collateral Assignment? .... ☐ Yes ☐ No

II. INFORMATION ABOUT POLICY(IES) OR CONTRACT(S) TO BE EXCHANGED.

Absolute Assignment of Ownership/Beneficiary Change. (Submit separate copy of this form for each life insurance company.)

Replaced Insurer and Address: ______

Insured: ______ Owner: ______ Policy Number: ______

As the sole owner of the policy(ies) or contract(s) listed in Section II above, I hereby agree to exchange such policy(ies) or contract(s) pursuant to Section 1035 of the Internal Revenue Code as part of a single integrated transaction for the ReliaStar Life Insurance Company, Security Life of Denver Insurance Company and Southland Life Insurance Company policy or contract described in Section III below, which I believe better suits my needs.

For applicable products only: If any loan amount is carried over, the dollar amount of the loan that is transferred, including accrued interest on the loan, will be considered to be premium paid for the new policy, together with any cash values that are transferred and any new premium paid with the application.

In consideration of ReliaStar Life Insurance Company, Security Life of Denver Insurance Company and Southland Life Insurance Company furnishing me with this Agreement and assisting me with this proposed exchange of insurance policies under Section 1035 of the Internal Revenue Code, I agree to be bound by all TERMS and CONDITIONS set forth in Section VI of this Agreement, (printed on the back of this page) which by my signature below I acknowledge that I have read and understand.

For consideration received, the undersigned policyowner herby assigns and transfers all rights, title and interest, without exception, in the above policy or policies to the Company. Accordingly, the company has the right to change the beneficiary to itself, surrender the policies, and receive the entire surrender values.

This certifies that no bankruptcy proceeding, attachments or other lien or claim is now pending against the policyowner.

III. INFORMATION ABOUT POLICY APPLIED FOR.

Policy Kind: ______ Proposed Insured: ______ Owner: ______

IV. LOAN ROLLOVER

☐ Carry over any existing loan to the extent that the Company's rules allow. Loan Amount: $ ______

☐ DO NOT carry over any existing loan. ☐ No outstanding loan.

V. LOST POLICY CERTIFICATE FOR POLICY NUMBER ______

The undersigned Owner(s) hereby certifies that the above referenced policy contract has been ☐ lost or ☐ destroyed. (Please check one.)

Certification – Under penalty of perjury, the undersigned certifies that the number shown below is the policyowner's correct taxpayer identification number.

Signed this ______ day of ______, 20 ____.

______
Witness

______
Current policyowner and title if corporation or trustee

______
Signature of owner's spouse

______
If a firm or corporation is owner, print its name. Also have an officer sign as owner.
(Community property states only AZ, CA, ID, LA, NM, NV, TX, WA, WI)

______
Social Security Number or Employer Identification Number

Assignee Release – This undersigned collateral assignee hereby releases any and all interest such assignee has in the above policy or policies.

______
Witness

______
Collateral Assignee

Beneficiary Change – As the Absolute Assignee and Policyowner of the above policies, the Company requests that all prior beneficiary designations be revoked and the Company be made sole beneficiary of the above policy or policies. (See section VI for terms and conditions.)

By: ______
Authorized Representative

VI. TERMS AND CONDITIONS

1. Absolute Assignment of Policy(ies) and Contract(s)

For value received, the Owner named in Section II hereby irrevocably transfers, delivers and assigns to ReliaStar Life Insurance Company, Security-Connecticut Life Insurance Company, Security Life of Denver Insurance Company and Southland Life Insurance Company (the "Company") all rights, title and interest in and to all policy(ies) and contract(s) listed in Section II. This Assignment revokes all previous beneficiary designations and settlement options for such policy(ies) and contract(s).

2. No Encumbrances

As of the date of this Agreement, the Owner represents and warrants for each policy or contract listed in Section II:

A. No policy loans are outstanding (exempt for FlexDesign VUL and all other applicable products);
B. No assignments (other than this one) currently exist;
C. No garnishments, liens or levies currently exist against any policy or contract listed;
D. No other person, firm, corporation or governmental unit has any legal or equitable claim against such policy or contract.

3. Legal Status of Existing Insurer(s)

As of the date of this Agreement, the Owner represents and warrants that the insurer named in Section II:

A. Has not informed the Owner it is unable to pay its claims or debts as they become due;
B. Has not informed the Owner that it has invoked a contractual right to delay payment for a period of up to six months;
C. Has not filed a petition for relief under U.S. Bankruptcy Laws, or similar laws of any state;
D. Is not the subject of any action in law or equity for the appointment of any receiver, administrator, trustee, liquidator, custodian or conservator;
E. Is not the subject of any action or proceeding for the dissolution, termination, reorganization or suspension of its operations or any material or substantial portion thereof.

4. Change in Legal Status of Existing Insurer

The Owner agrees that if the legal status of the insurer named in Section II changes or shall be determined by the Company to be different from the representations and warranties set forth in 3, above, before the Company actually receives the cash surrender value of any policy or contract listed in Section II, the Company in its sole discretion may reassign ownership of such policy(ies) or contract(s) to the Owner and terminate this Agreement, or, the Company may continue to attempt collection of the cash surrender values of such policy(ies) or contract(s). In the event the Company elects to continue to attempt collection of the cash value of any such policy(ies) or contract(s), the Owner agrees to execute and deliver to the Company such further documents as it may require in order to complete this transaction, including without limitation, the statement required by I.R.S. Revenue Procedure 92-44.

5. Legal Status of Existing Policy(ies) or Contract(s)

As of the date of this Agreement, the Owner represents and warrants that the policy(ies) and contract(s) listed in Section II are in force and have not lapsed. The Owner agrees that the Company shall have no responsibilities to pay any premiums in respect of such policy(ies) and contract(s) which are now due, or which become due after the date of this Agreement. The Owner acknowledges and understands that the insurer named in Section II may delay or defer payment of the cash surrender value of such policy(ies) and contract(s) for up to six (6) months from the date such insurer receives the Company's request to surrender such policy(ies) and contract(s), and that such policy(ies) or contract(s) may lapse during such period unless the Owner pays enough premium to prevent lapse. The Owner agrees that the Company is under no duty to notify the Owner of the pending lapse of such policy(ies) or contract(s). The Owner knowingly assumes the risk of such lapses.

6. Death of Proposed Insured

If the Proposed Insured dies on or after the date of this Agreement, the Owner understands and agrees:

A. A death claim may (or may not) be paid by the Company subject to the terms of the Conditional Receipt. The New Policy will be delivered to the Owner only if the Company has determined to its own satisfaction that the person insured thereunder is insurable on the date of delivery and that the amount of premium required by the Company upon delivery of the Policy has or will be paid in accordance with either the Conditional Receipt or External Exchange Policy Delivery Receipt; or

B. Any death claim payable under the policy(ies) or contract(s) listed in Section II, because of the Absolute Assignment set forth in 1 above, will not be paid to the Owner's beneficiaries but will be paid solely to the Company as the new Owner and beneficiary, and may therefore be applied, directed or utilized solely for the Company's benefit.

7. Free Look Provision

The Owner acknowledges and agrees that if the Owner elects to exercise his or her privilege to return any Company policy or contract issued in this proposed exchange, then the Company's only obligation shall be to pay the Owner the full cash surrender value the Company has received at its Home Office from the insurer named in Section II. The Owner acknowledges that the insurer named in Section II may not permit the Owner to reinstate a surrendered policy or contract.

8. Effective Date for Crediting Interest

The Owner understands and agrees that the interest rate credited by the Company on the Company policy or contract applied for and the length of the guarantee period, if any, applicable to such interest rate, will be the rate and guarantee period in effect when the Company receives at its Home Office the cash surrender value of the policy(ies) or contract(s) listed in Section II. The Owner understands and agrees that this rate may be lower than the rate in effect on the date of this Agreement and the guarantee period may be shorter than the guarantee period in effect on the date of this Agreement.

9. Responsibility for Tax Consequences

The Owner understands and agrees that neither the Company nor its Agents, in providing this Agreement and in facilitating this exchange of insurance policies are thereby providing the Owner with legal or tax advice regarding this transaction. The Owner agrees to consult his or her own tax professional for advice regarding the tax consequences of this transaction.