

# Group Term Life Application State Bar of South Dakota

Please complete the entire application. The proposed insured should fill out this application. A spouse or employee can apply for coverage using a photocopy of this form. *Please print clearly in dark ink and mail in the envelope provided to Hagan Benefits, Inc., P.O. Box 5090, Sioux Falls, SD 57117-5090.*

# 1

## Tell us about yourself

Name of Association

<b>State Bar of South Dakota</b>	<b>GL-28495-5</b>
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Are you applying as:     Association member     Spouse of member     Employee of member

Your name ( <i>last, first, middle</i> )			<input type="checkbox"/> Female <input type="checkbox"/> Male
Date of birth	Height	Weight	Social Security number
Address			
City	State	Zip	
Home Phone	Work Phone		
Member's name, if applying as a spouse ( <i>last, first, middle</i> )			

Owner (if other than yourself.) *The owner controls all rights to the certificate.*

Name	Address	
City	State	Zip

• Have you used tobacco products of any kind in the last 12 months?     Yes     No

• Check box(es) to purchase:

Accidental Death and Dismemberment Benefit  
(*Equal to life benefits to a maximum of \$250,000*)

Dependent's insurance: (select an amount per child)  
 \$2,000     \$4,000     \$6,000     \$8,000     \$10,000

• Will this proposed insurance replace any of your current life insurance (other than term life) or annuities?     Yes     No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

• If you are a **new** applicant, indicate *initial* amount of coverage applied for (See brochure for eligible coverage amount):

\$ \_\_\_\_\_  
 in \$10,000 increments

• If you are **increasing** coverage, indicate amount of *additional* coverage applied for with this application:

\$ \_\_\_\_\_  
 in \$10,000 increments

# 2

## Beneficiary information

List one or more beneficiaries below. Beneficiaries may include your spouse, children, parents, charities or anyone you wish. List the percent each will receive. The total must equal 100 percent.

Name	Address	Relationship	Percent

# 3

## Provide us with this health information

Yes No

- Have you, for any condition during the past 12 months, consulted a physician, received surgical or medical care, or taken prescribed medication?
- Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus?
- Have you ever had, or been treated for nervous, brain or lung disorders, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury or other disease or disorder?
- Have you ever sought help or received counseling or treatment for anxiety/depression, alcohol or drug use, or are you currently using illegal drugs?
- Have you ever applied for insurance that was declined, postponed or modified in any way?

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

NATURE OF ILLNESS, INJURY OR OPERATION	DATE(S) OF TREATMENT	REMAINING EFFECTS	NAME & ADDRESS OF DOCTORS & HOSPITALS

- List the name and address of your regular physician and the date you last consulted him or her:

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# 4

## Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

I hereby authorize my physician, hospital, clinic, insurance company, Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me to give ReliaStar Life Insurance Company, any and all information about me, with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I understand all or part of this information may be sent to MIB, Inc. it may also be made available to any ReliaStar Life reinsurer, employee, or contractor who processes transactions that concern any insurance I may have applied for or have with ReliaStar Life. A photographic copy of this authorization shall be as valid as the original. This form will be valid for 30 months from the date shown below or for 2 years from the date the coverage is issued, whichever is earlier.

I acknowledge that I have been given and have read ReliaStar Life's Information Practices Notice and Notice Regarding Medical Information Bureau.

Your signature	Date signed
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Signature of Owner (if other than yourself)	Date signed
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<b>FOR OFFICE USE ONLY</b>	
Signature of Licensed Insurance Rep.	
Group Plan #	<b>GL-28495-5</b>
Effective Date	_____