

TERM APPLICATION

ReliaStar Life Insurance Company, Minneapolis, MN

A. PRODUCT INFORMATION

- 1. Initial Term Period: 10 Year 15 Year 20 Year 30 Year Other _____
- 2. Face Amount \$ _____
- 3. Location of Sale (city, state) _____ Date _____

B. RIDER INFORMATION *Select only if available with product. Not all riders are approved in all states.*

- Waiver of Premium Rider
- Children's Insurance Rider (Complete Children's Insurance Rider Application.) \$ _____
- Other _____ \$ _____

C. PROPOSED INSURED INFORMATION

- 1. First Name _____ MI _____ Last Name _____
- 2. Date of Birth _____ Birth State and Country _____
- 3. Sex: M F Marital Status: Married Separated Divorced Single Widowed
- 4. SSN/Government Issued ID# _____ Phone _____
- 5. Driver's License Number and State _____
- 6. Residence Address _____
(P.O. Boxes are not permitted, other than APO/FPO) City _____ State _____ ZIP _____
- 7. Is the Proposed Insured a U.S. Citizen? (If "No", complete the Foreign Travel and Residence Questionnaire.)..... Yes No
- 8. Occupation (include duties) _____
- 9. Employer _____ Employer Phone _____
- 10. Employer Address _____
City _____ State _____ ZIP _____
- 11. Proposed Insured Annual Earned Income _____ Annual Interest & Other Income _____
- 12. Total Net Worth _____
- 13. Has the Proposed Insured ever used tobacco or nicotine products of any type? Yes No
If "Yes", indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

D. PROPOSED INSURED PERSONAL HISTORY

- 1. Has the Proposed Insured ever declared bankruptcy? (If "Yes", provide details in chart below, including date discharged.)..... Yes No
- 2. Is the Proposed Insured, or do they intend to become a member of the armed forces, including the Reserves or National Guard? (If "Yes", complete Military Questionnaire.)..... Yes No
- 3. In the next 5 years, does the Proposed Insured intend to travel or reside outside the United States or Canada (other than a two week or less vacation to Western Europe or the Caribbean)? (If "Yes", complete the Foreign Travel and Residence Questionnaire.)..... Yes No
- 4. Does the Proposed Insured anticipate flying a plane (other than as a commercial pilot), racing motor boats, automobiles or motorcycles, or participating in sky-diving, hang-gliding or other hazardous activities? (If "Yes", complete the appropriate hazardous activities questionnaire.)..... Yes No

5. Except for traffic violations, has the Proposed Insured been the subject of or convicted in a criminal proceeding? (If "Yes", provide details in chart below.)..... Yes No
6. Has the Proposed Insured in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? (If "Yes", provide details in chart below.)..... Yes No
- For any "Yes" answer to questions 1, 5 or 6, please record information in the chart below.

Ques. #	Explanation

E. BENEFICIARY INFORMATION

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

Name (First, MI, Last)	DOB	Relationship	%	Beneficiary Type
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

If beneficiary is a Trust or Corporation, provide name and date of trust agreement and state of incorporation.

Name of Trust/Corporation _____ Date of Trust _____ State of Incorporation _____

F. OWNER (PAYOR) Complete only if owner is to be other than Proposed Insured.

1. Owner is: Individual Corporation Trust Sole Proprietorship Partnership Other _____

2. Full Name _____

3. Relation to Proposed Insured _____

4. Residence Address _____
(P.O. Boxes are not permitted other than APO/FPO) City State ZIP

5. Billing Address _____
City State ZIP

6. Phone _____ SSN/TIN or Government Issued ID# _____

7. Driver's License Number/State (individual only) _____ Date of Birth _____

8. Trust Contact Name _____ Date of Trust _____

9. Type of Trust: Revocable Irrevocable Purpose of the Trust _____

10. State of Incorporation _____ Name of Trustee/Corporate Officer _____

11. Does the above trustee have sole authority to act on behalf of the Trust? Yes No
(If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees.)

G. REPLACEMENT INFORMATION (Applies to both Owner and Proposed Insured.)

If you intend to replace existing coverage, tell the Agent of your intention and answer "Yes" to the replacement questions (#2 and #3 below). State law may require the Agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Agent if you are unsure.

K. IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

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

ING Service Center
Life New Business
P.O. Box 5052
Minot, ND, 58702-5052.

L. STATE REQUIRED NOTICES

For Applicants in Arkansas, District of Columbia, Hawaii, Louisiana, Oklahoma and Tennessee:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime and in certain states, a felony. Penalties may include imprisonment, fine, denial of benefits, or civil damages.

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 and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant 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.

KENTUCKY:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OHIO:

Any person who, with intent to defraud or knowing that he 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.

M. BACKDATING DISCLOSURE

As a policyholder, you may elect to backdate your policy, which enables you to gain benefits of a lower age for the purposes of calculating costs of insurance charges on your policy.

There are some inherent costs associated with your decision to backdate your policy. For each month that your policy is backdated the applicable costs of insurance charges are accumulated and deducted from your initial premium payment. If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

This page must be given to the Proposed Insured.

N. AUTHORIZATION AND ACKNOWLEDGEMENT

The undersigned Owner and Proposed Insured declare: By completing this life insurance application, I understand that I am applying for life insurance coverage issued by ReliaStar Life Insurance Company, referred to 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: 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; Prescription drug records and related information maintained by physicians, pharmacy benefit managers and other sources; 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 collect 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 collect 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, but not to the extent action has been taken. 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.

For any life insurance application 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 or her 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 ____ am/pm and ____ am/pm. My daytime phone number is (____) _____.
- I know that I have a right to receive a copy of this form and a photocopy 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.

VERIFICATION:

Each of the undersigned also declares that:

- 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. I understand that the Company may seek to rescind or cancel the insurance coverage if there is any material misrepresentation.
- This application consists of Part I, appendices and supplemental questionnaires, and will be the basis for any coverage issued on this application. Any coverage issued on this application will take effect only upon satisfaction of all of the Company's requirements, except as otherwise provided in the Conditional Receipt, if issued, with the same date as this application. 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. 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.
- I certify, under penalty of perjury, that my Social Security/tax identification number(s) is(are) shown and is(are) correct and that I am not subject to back-up withholding.

All completed materials must be sent to the Administrative Office at: ING Service Center, P.O. Box 5052, Minot, ND 58702-5052 or faxed to 866-308-7743.

Signature of Proposed Insured (if age 15 or older) _____

Signed at: (city/state) _____ Date _____

Signature of Owner (if other than the Proposed Insured) _____ Date _____

Print Owner/Trustee Name _____

Signature of Parent or Guardian (if the Proposed Insured is a minor) _____

Signature of Writing Agent _____

Print Writing Agent Name _____

Writing Agent State Lic. # _____ Writing Agent # _____

Name of Agent _____

Agent State Lic. # _____ Agent # _____

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization is HIPAA compliant.

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(please print)* _____

Date of Birth _____ SSN/ITIN _____

Proposed Insured/Patient Address _____

AUTHORIZATION INFORMATION

This will authorize:

_____ *(Physician, Clinic or Hospital Name)*

to release medical information to _____ *(the Life Insurance Agent/Agency).*

Authorized Life Insurance Carrier(s) _____

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, according to the terms of this authorization. This includes any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Insurance Agent/Agency named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Insurance Agent/Agency may provide the information to the listed carrier(s) so that they may: 1) underwrite

my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Insurance Agent/Agency.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Insurance Agent/Agency named above at the following address.

Attention: Privacy Official

Agency Address _____

City _____ State _____ ZIP _____

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Proposed Insured/Patient or
Personal Representative Signature _____ Date _____

Description of Personal Representative's
Authority or Relationship to Patient *(please print)* _____

A copy of this Authorization must be given to the Proposed Insured.

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 phone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with ReliaStar Life 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 will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is 866-692-6901 and fax is 866-346-3642.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

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.

This page must be given to the Proposed Insured and/or Owner.

VALUABLE INFORMATION ABOUT YOUR TERM LIFE INSURANCE PURCHASE

ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO



Thank you for considering ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company") for your life insurance needs. We offer various life insurance products that have different features, benefits and costs. Your professional insurance agent may work with many life insurance companies, and we are pleased that your agent has presented one of our products to you.

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

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

This is a general discussion of the compensation we pay for the sale of our policies. We pay commissions and other sales expenses from our general assets and revenues, including amounts we earn from fees and charges under our policies. The price of an insurance policy is set by the Company and reflects the compensation we pay for the sale of the policies. It also covers costs we incur for the design, manufacture and service of our policies, for policy benefits and features including guarantees, and for the investment management needed to support the policies' values. We are committed to providing top-quality insurance products to our customers and are pleased that your professional insurance agent trusts us to deliver on your long-term insurance needs.

This notice must be given to the Proposed Insured/Owner.

LATEST FACTS ABOUT AIDS

*If Your Test For Antibody to the AIDS Virus Is Positive**

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

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

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

THE AIDS ANTIBODY TEST

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

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

WHAT DOES A POSITIVE ANTIBODY TEST MEAN?

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

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

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

HOW CAN I PROTECT MY HEALTH?

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

HOW CAN I PROTECT OTHERS?

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

- Be sure to tell your sex partners about your positive test result. Avoiding sex would eliminate any risk of spreading the virus by sexual means; however, if you and your partner decide to go ahead, be careful to protect him or her from contact with your body fluids, which may carry the AIDS virus. ("Body fluids" includes blood, semen, urine, feces, saliva, and vaginal secretions.) Use a condom, which will help reduce the chances of spreading the virus, and avoid practices, such as anal intercourse, that may injure body tissues and make it easier for the virus to enter the bloodstream. Oral-genital contact should also be avoided, as should open-mouthed, intimate kissing.
- People who have been your sex partners may have been exposed to the AIDS virus. If you have used intravenous drugs, anyone you have shared needles and syringes with may have been exposed too. You should tell these persons about your positive test result and urge them to seek

counseling and antibody testing from a doctor or health clinic.

- Don't share toothbrushes, razors, tweezers, or other items that could become contaminated with blood.
- If you use drugs, consider enrolling in a drug treatment program to help protect your health. Remember that needles and other drug equipment must never be shared.
- Don't donate blood or plasma, body organs, other body tissue, or sperm.
- Clean spills of blood or other body fluids on household or other surfaces with freshly diluted household bleach — one part bleach to 10 parts water. (Don't use bleach on wounds.)
- When you seek medical help, tell the doctor, dentist, eye doctor, or other health worker who gives you care about your positive AIDS antibody test, so that steps can be taken to protect you and others.
- If you are a woman with a positive test result, consider avoiding pregnancy until more is known about the risks of transmitting the AIDS virus to your baby. If you do become pregnant, it's important to see a doctor for regular care during your pregnancy. Because the AIDS virus has been found in breast milk, you should not breastfeed your baby.

WHAT ABOUT THE ORDINARY ACTIVITIES OF MY DAILY LIFE?

You should be careful to follow the normal practices everyone needs to maintain good health: Eat a well-balanced diet, exercise, rest, and try to manage your life in a way that avoids undue stress. But there's no reason to change your activities in ways beyond those that have already been discussed.

Your positive test status should not affect your contacts with people at work or in social situations. Special precautions are not necessary: The AIDS virus is not spread by ordinary nonsexual contact such as shaking hands, sharing an office, coughing or sneezing, preparing or serving food, or sharing toilet facilities.

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

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

A FINAL WORD

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

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

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

- Your doctor.
- Your state or local health department.
- The Public Health Service's toll-free hotline: 1-800-342-AIDS.
- Your local chapter of the American Red Cross.

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

**Article reprinted with permission of the author. American Red Cross.*

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



ReliaStar Life Insurance Company
Home Office: Minneapolis, MN
Administrative Office:
P.O. Box 5075
Minot, ND 58702-5075

LIVING BENEFIT RIDER DISCLOSURE STATEMENT

The accelerated benefit rider, better known as ReliaStar's Living Benefit Rider, allows the owner to access a portion of the life insurance death benefit if the insured becomes terminally ill (life expectancy of 6 months or less as determined by a physician). The benefit is always payable to the owner.

There is no additional premium required to issue this rider. If you request an accelerated benefit, an interest charge and an administrative expense charge will be deducted from the amount you request.

When an accelerated benefit is paid, the death benefit, cash values and loan values of the policy will be reduced proportionally. The amount will be determined at the time you request a Living Benefit payment.

For example, suppose you purchase a policy with a \$100,000 death benefit. Later, you request a Living Benefit payment of \$25,000. Any charges noted above would be deducted from the \$25,000 and the resulting total would be your Living Benefit payment. The death benefit on your policy would then be reduced to \$75,000, and any required premium would be reduced proportionally. If your policy has cash values, those accumulations would also be reduced proportionally.

Limitations of the Accelerated Benefit:

- (a) The rider is not intended to replace health or disability coverage. Rather, it provides an added source of funds to meet critical needs during a difficult time. You choose how the funds will best meet your needs. There are no restrictions on how a Living Benefit payment can be used.
- (b) Accelerated benefits payable under this rider may or may not be taxable. You should consult your personal tax advisor.
- (c) Receipt of accelerated benefits under this product may affect medicaid and supplemental security income ("SSI") eligibility.

If at some future point in time, you decide that you no longer wish to carry the Living Benefit Rider on your coverage, you may request that it be removed. The Living Benefit Rider will automatically terminate when the life insurance policy matures.

The Living Benefit Rider is subject to eligibility requirements.

CREDIT CARD PAYMENT AUTHORIZATION AND ELECTRONIC FUNDS TRANSFER

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

A. CREDIT CARD PAYMENT AUTHORIZATION

This service is not available in Alaska, California, Maryland, New Jersey, New York and North Carolina.

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

Insured Name (Please print.)	Policy #	Payment Amount

Premium Payment Mode: Monthly Quarterly Semi-Annual Annual

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

Account # _____ Expiration Date (month and year) _____
 (16 digits)

Credit Card Type: MasterCard Visa Discover Billing Zip Code _____

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

Signature of Cardholder¹ _____

B. ELECTRONIC FUNDS TRANSFER

What is the EFT plan?

The EFT plan allows us to pay your policy premiums by automatically withdrawing funds from your financial institution's account. You will receive a notice that premium is due and a receipt for the amount withdrawn.

What happens if my financial institution does not honor a withdrawal?

If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. Premium payments are necessary to fund your policy; therefore, you will be required to send us a replacement payment. If we do not receive a replacement payment within the time required by your specific policy, your policy will enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage. To help prevent this, we encourage you to obtain overdraft protection from your bank.

Will the deductions always be for an equal amount?

Your premium payments will always be for the same amount. If you make any changes to your policy, including conversions or renewals, your premium payments may increase. We will notify you in advance of any withdrawals or premium increases.

How can I cancel the EFT plan?

To cancel, you must provide notice to us in writing. Once we receive your request, we will stop the plan within 7 – 10 business days. We may also terminate the EFT plan without notice if any withdrawal is not honored or 30 days after we provide written notice to the policy owner.

If the plan is cancelled, you must pay any unpaid and future premiums directly to us on the premium due date. Termination of the EFT plan does not change the premium due dates.

I'd like to enroll. Where do I sign?

Please read the following agreement and sign and date this form.

Authorization Agreement for Prearranged Payments

I authorize the Company to withdraw funds from my checking or savings account, identified on the next page, to pay premiums on my life insurance policy. This authorization will remain in effect until the Company has received a written request from me to terminate this agreement.

¹Payment cannot be processed without signature.

B. ELECTRONIC FUNDS TRANSFER (EFT) (CONTINUED)

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

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

Payment Frequency: Monthly Quarterly Semi-Annual Annual

Insured Name (Please print.)	Policy #	Deduction

Request Specific Draft Date _____

Bank Name _____

Bank Address _____

City _____ State _____ ZIP _____

Account type: Checking Savings Name(s) on Account _____

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

Tape voided check or deposit slip here.

Routing Number _____ Account # _____
(9 digits)

Account Owner Signature _____ Date _____

SSN/TIN _____ Phone # _____



Insurer Name _____

Insurer Address _____

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING – CALIFORNIA

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

DESCRIPTION AND PURPOSE OF TESTS TO BE PERFORMED

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

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

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

POTENTIAL USES

If your HIV test results are positive, the company will report a "nonspecific abnormality" of your blood to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many other blood abnormalities are reported to the Bureau under the same classification.

LIMITATIONS

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

- a. False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
- b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test results to develop after a person is infected.

MEANING OF THE TEST RESULTS

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

DISCLOSURE OF TEST RESULTS

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

CONFIDENTIALITY OF TEST RESULTS

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

NOTIFICATION OF TEST RESULT

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

Name of physician for reporting a possible positive test result:

Address: _____

Phone: _____

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

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

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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

Signature of Proposed Insured or Parent/Guardian

Date Signed

Name of Proposed Insured (Print)

Address

City, State, Zip

**ORIGINAL TO COMPANY
COPY TO PROPOSED INSURED**

AGENT'S REPORT

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

Agent Name (Please Print.)	Agent ID #	% Split	General Agent #	General Agent Name

Each licensed agent will share equally unless otherwise indicated.

A. COMPLIANCE INFORMATION

- Did you obtain the Proposed Insured's Medical Declarations in person and record them in the presence of the Proposed Insured? (If "No", explain why and arrange for an exam.) Yes No
- Have you delivered the Consumer Privacy Notice to the Proposed Insured(s) or Proposed Owner? Yes No
- Did you meet personally with the Proposed Owner and review their government issued ID? (If "No", explain in Section D.) Yes No
- If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Insured or Proposed Owner? Yes No
- All sales materials used during the sale process were approved by the Company. The following are the approved sales materials used in my sales presentation: _____
- Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policyowner no later than at the time of the policy delivery.) The Company requires that all replacement sales are made in accordance with the Company's corporate policy. If this particular sale is NOT in accordance with the Company's corporate replacement policy, please check here and attach an explanation.
- Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? Yes No
- Have there been any discussions in which the Proposed Owner has been solicited to directly or indirectly sell, assign, settle or otherwise transfer the proposed policy (or the rights to its death benefit), or an ownership or beneficial interest in an entity that will own the proposed policy, to a life settlement company or other third party? Yes No
If "Yes", please provide details. _____
- Will the proposed policy on the life of the Proposed Insured(s) replace a policy that has been sold, assigned, or settled to or with a settlement or viatical company or any other person or entity? Yes No
If "Yes", please provide details. _____
- Will the premiums, now or in the future, be financed? Yes No
If "Yes", and the proposed policy is or will be financed with a loan from a lender identified in the Company's "Hybrid Premium Financing Guidelines," identify the lender below. Otherwise, identify the lender and describe the interest rate, term of the loan and required amount and type of collateral. _____
If "No," please identify the source of funds for initial and subsequent premiums, and describe any transactions of which you are aware that the Proposed Owner and/or Proposed Insured(s) engaged in, or will engage in, to generate such funds (e.g., the sale, assignment or mortgage of property). Please also describe the relationship of the source to the Proposed Owner and/or Proposed Insured(s). _____

B. PROPOSED INSURED/OWNER INFORMATION

- How long have you known the Proposed Insured? _____ 2. Are you related? Yes No How? _____
- How much insurance does the Proposed Insured's spouse own payable to the Proposed Insured or other dependents? \$ _____
- If this application is for a juvenile, please indicate the amount of life insurance in force on each parent or sibling.
Father \$ _____ Mother \$ _____ Sibling \$ _____
- Please check the Underwriting requirements ordered: Blood Profile/HOS Inspection Report MD Exam
 Treadmill EKG EKG Paramedical Exam Paramed Company _____

C. REMARKS (Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.)

D. ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent or Producer Agreement ("Agreement"), whichever is applicable, including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker/Dealer and do not hold an Agreement such that this language is inapplicable.

I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

Agent Signature(s) _____ Date _____
 Contact for Requirements _____ Agent SSN _____
 Agent Phone _____ Fax _____ Email _____

TEMPORARY INSURANCE RECEIPT

- ReliaStar Life Insurance Company, Minneapolis, MN
- Security Life of Denver Insurance Company, Denver, CO



Premium has been received from _____ in the amount of \$ _____ in payment of the first full modal premium for an insurance policy applied for on the life (lives) of _____ (Proposed Insured/ Proposed Other Insured), for whom an application (the "Application") dated _____ has been made to ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company"). **This Temporary Insurance Receipt does not provide any coverage except as provided herein. If any of the below representations is answered YES or LEFT BLANK by the Proposed Insured(s), 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.**

I. REPRESENTATIONS (For each Proposed Insured named above)

Has any 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? Yes No
- b. ever had, or now have, any type of heart disease, stroke, or other vascular disease? Yes No
- c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the brain or immune system? Yes No
- d. attained age 70? Yes No

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) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

There is no insurance coverage if:

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

Proposed Owner Name (Please print) _____ Date _____

X Proposed Owner Signature _____ Signed at (city/state) _____

Proposed Insured Name (Please print) _____ Date _____

X Proposed Insured Signature (if other than the Proposed Owner) _____ Signed at (city/state) _____

Proposed Other Insured Name (Please print) _____ Date _____

X Proposed Other Insured Signature _____ Signed at (city/state) _____

X Writing Agent Signature _____ Date _____

Writing Agent Name (Please print) _____ Agent Phone # _____

1st Copy to Administrative Office

2nd Copy to Owner

TEMPORARY INSURANCE RECEIPT

- ReliaStar Life Insurance Company, Minneapolis, MN
- Security Life of Denver Insurance Company, Denver, CO



Your future. Made easier.SM

Premium has been received from _____ in the amount of \$ _____ in payment of the first full modal premium for an insurance policy applied for on the life (lives) of _____ (Proposed Insured/ Proposed Other Insured), for whom an application (the "Application") dated _____ has been made to ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company"). **This Temporary Insurance Receipt does not provide any coverage except as provided herein. If any of the below representations is answered YES or LEFT BLANK by the Proposed Insured(s), 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.**

I. REPRESENTATIONS *(For each Proposed Insured named above)*

Has any 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? Yes No
- b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?..... Yes No
- c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the brain or immune system? Yes No
- d. attained age 70? Yes No

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) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

There is no insurance coverage if:

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

Proposed Owner Name *(Please print)* _____ Date _____

Proposed Owner Signature _____ Signed at *(city/state)* _____

Proposed Insured Name *(Please print)* _____ Date _____

Proposed Insured Signature *(if other than the Proposed Owner)* _____ Signed at *(city/state)* _____

Proposed Other Insured Name *(Please print)* _____ Date _____

Proposed Other Insured Signature _____ Signed at *(city/state)* _____

Writing Agent Signature _____ Date _____

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

1st Copy to Administrative Office

2nd Copy to Owner

NEW BUSINESS TRANSMITTAL CHECKLIST



A. UNDERWRITING INFORMATION

Type of application submitted: Formal Application Informal/Trial Application Express Application
 Application submitted to: ReliaStar Life Insurance Company: P.O. Box 5075, Minot, ND 58702-5065
 Security Life of Denver Insurance Company: P.O. Box 5065, Minot, ND 58702-5065

Prior to submission, case discussed with: _____

Product _____ Face Amount \$ _____

B. APPLICANT INFORMATION

Date _____ Name of Applicant _____ Policy #, if applicable _____

C. AGENT INFORMATION

Agent Name _____

Please indicate all Agent numbers associated with the following underwriting company and product line:

ReliaStar Life Insurance Company (Fixed Products) _____

ReliaStar Life Insurance Company (Variable Products) _____

Security Life of Denver Insurance Company (Fixed Products) _____

Security Life of Denver Insurance Company (Variable Products) _____

New Business Contact Person _____ Phone Number _____

Fax Number _____ Email Address _____

Policy Delivery Address _____

D. GENERAL AGENT INFORMATION

General Agent Name _____

Please indicate all General Agent numbers associated with the following underwriting company and product line:

ReliaStar Life Insurance Company (Fixed Products) _____

ReliaStar Life Insurance Company (Variable Products) _____

Security Life of Denver Insurance Company (Fixed Products) _____

Security Life of Denver Insurance Company (Variable Products) _____

New Business Contact Person _____ Phone Number _____

Fax Number _____ Email Address _____

E. VERIFICATION

The application for life insurance must be completed and accompanied by all required state-specific forms. Please refer to the ING website www.ingvfc.com for the correct form numbers.

1. Is the Agent's Report complete? Yes No
 The writing agent/registered representative must be *licensed and appointed* in the state where the application was signed. The writing agent/registered representative must complete and sign the Agent's Report. The Independent General Agent (if applicable) must also sign and include his or her Agent number(s) on the Agent's Report.
2. Has the application been signed and dated? Yes No
3. Has the Consumer Privacy Notice and State Required Notice been given to the applicant? Yes No
4. Have all questions been fully answered? Yes No
5. Have all "Yes" answers been given full explanation and/or have the appropriate questionnaires been completed? . Yes No
6. Has a signed illustration, In Lieu of Illustration or Acknowledgement and Certification of No Illustration been submitted? Yes No
7. Was licensing/contracting paperwork submitted simultaneously with this application? Yes No

F. STATE-SPECIFIC REQUIREMENTS

The following state-specific requirements are enclosed:

- Application for Life Insurance
 - Disclosure Statement(s)
 - Replacement Notice(s)
 - HIV Consent
 - Comparative Information Notice (Must be included if the application is a replacement in FL or WV)
 - Out-of-State Verification (Required based on signed state/resident state)
 - Children's Term Insurance Rider Application
 - Regulation-60 paperwork (NY ONLY)
 - Original 1035 Exchange/Service Request
 - Check in the amount of \$ _____
 - Additional Application/Alternate Application
- Product _____
- Face Amount \$ _____

Variable Products ONLY: Has the proper Fund Allocation supplement been submitted?..... Yes No

Please specify the status of the following items:

- 1. Medical Examination..... Attached To Follow
- 2. Blood Profile/Home Office Specimen (HOS)..... Attached To Follow
- 3. Electrocardiogram (EKG)..... Attached To Follow
- 4. Attending Physicians Statement (APS)..... Attached To Follow
- 5. Inspection Report (IR)..... Attached To Follow
- 6. Motor Vehicle Report (MVR)..... Attached To Follow
- 7. Electronic Funds Transfer (EFT)..... Attached To Follow
- 8. Questionnaires..... Attached To Follow
- 9. Conditional Receipt/Temporary Insurance Agreement..... Attached To Follow
- 10. MIB Authorization (must be signed)..... Attached To Follow