APPLICATION INSTRUCTIONS

THE FLORIDA BAR MEMBER GROUP TERM LIFE INSURANCE PLAN

1. COMPLETE APPLICATION FORM

Make sure to complete the form in its entirety. Incomplete applications will not be accepted. Illegible print may delay processing of application.

2. COMPLETE PAYMENT METHOD

Payment Option 1 - Monthly Auto Pay
If you elect to pay by Monthly Bank Draft (ACH), you do not need to send any premium. Upon approval of your application by the insurer, we will automatically draft your account on a monthly basis. Make sure to complete the Authorization section and include a VOIDED check.

Payment Option 2 - Direct Annual Billing
If you elect the Direct Annual Billing method, upon approval of your application by the insurer, you will receive an initial invoice for the amount of premium due to pay your coverage through the end of the plan year (to December 31st.)
You will receive annual invoices thereafter, which will be due on January 1st.

3. FAX OR MAIL FORMS TO:

You may use this form as a FAX COVER

Fax to: (904) 396-2091

Your Name: _____ Date: _____
Attn: Application/Processing

Or Mail to:

Program Administrator
Member Benefits
7645 Gate Parkway, Suite 101
Jacksonville, FL 32256

ANY QUESTIONS? CALL TOLL-FREE: 1-800-282-8626

SATISFACTION GUARANTEED. YOU RISK NOTHING BY APPLYING NOW.
If you are not completely satisfied when you receive your Certificate of Insurance, just notify us within 30 days and we'll refund any premium you've paid, provided no claims have been submitted or paid. No insurance will be in force, and you will be under no further obligation.

MEMBER GROUP LEVEL TERM-LIFE INSURANCE PLAN FOR MEMBERS OF THE FLORIDA BAR

UP TO $1,000,000 IN COVERAGE

COMPETITIVE GROUP RATES

UNDERWRITTEN BY RELIASTAR LIFE INSURANCE COMPANY, A MEMBER OF THE VOYA® FAMILY OF COMPANIES, RATED "A" (EXCELLENT) BY A.M. BEST**

COVERAGE FOR SPOUSE, DOMESTIC PARTNER AND CHILDREN

If you are covered in this plan, your spouse or domestic partner is eligible to apply for up to 100% of your coverage amount. If you are a current member and your spouse is under age 66, able to conduct the normal activities of a person of like age and gender, and is in good health simply visit www.memberbenefits.com/floridabar to apply.

Child coverage of $10,000 is also available. One premium provides $10,000 of life insurance for all of your eligible unmarried dependent children, ages 6 months to 21 years, or to age 25 if a full-time student. Children ages 14 days to 6 months are eligible for $1,000 of coverage.

EXCLUSIONS

The only exclusion under this group term life policy is for suicide within the first two years of coverage or an increase in coverage. The optional Accelerated Life Benefit and AD&D benefit are subject to additional exclusions.

PROGRAM ADMINISTRATOR

For all inquiries, contact your program administrator: Member Benefits, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256. 1-800-282-8626.

DESIGNATE YOUR BENEFICIARY

You may designate one or more beneficiaries on the application form. Attach a separate sheet if needed. You may request to change your beneficiary at any time by contacting the plan administrator.

ORGANIZATION BEHIND THE COVERAGE**

Insurance underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. ReliaStar Life Insurance Company is rated "A" (Excellent) by A.M. Best. This is third highest of 15 ratings. A.M. Best Company assigns ratings from A++ to F based on a company's financial strength and ability to meet obligations to contract holders.

ADMINISTERED BY:

MB | MemberBenefits

VOYA® FINANCIAL

Policy Form LP08GP (product availability and plan provisions may vary by state).
This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern.

* The initial premium will not change during your level term period, unless the insurance company exercises its right to change the premium rates for all insureds covered under the group policy and with 60 days advance written notice. To keep coverage in force, premiums are payable up to the date of the group policy or coverage termination.

** Insurance underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy Form LP08GP (product availability and plan provisions may vary by state).

KEEP UP WITH YOUR FAMILY'S FINANCIAL NEEDS WITH UP TO $1,000,000 IN GROUP TERM LIFE INSURANCE COVERAGE

UP TO $1,000,000 IN LEVEL TERM PROTECTION AT GROUP RATES DESIGNED TO REMAIN LEVEL FOR 10 YEARS*

This plan is designed to provide an affordable way to update your family's financial security. As long as you are a current member of The Florida Bar, under age 66, and actively working at least 30 hours per week, you may apply for up to $1,000,000 of level term life insurance.

There are no investment structures, application fees, or annual policy fees, which can inflate cost, and because it's a Level Term Plan, your premiums are based on your age when you apply. Your rate is designed to not increase during the level term period*, regardless of changes in your health. This helps to make the plan a better value over time.

THE APPLICATION PROCESS

Fully complete all sections of the enclosed application and return to the program administrator. Providing complete and accurate information on your application can make the medical underwriting process quicker and easier.

All coverage is subject to underwriting approval by ReliaStar Life Insurance Company, and more medical information may be requested from you or from your attending physician(s). A physical exam, EKG, blood test or other information may also be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. These requirements will be at no cost to you. Acceptance into the life plan is not guaranteed.

COVERAGE EFFECTIVE DATE

Your coverage will become effective on the first of the month following approval of your application by ReliaStar Life, and once your first premium payment is made.

A PAY-OUT FOR TERMINAL ILLNESS OF UP TO $75,000

If you are terminally ill and have a life expectancy of six months or less, you can receive a portion of your death benefit before dying. This is called the accelerated life benefit. You can receive a payment of 50 percent of your coverage, to a maximum of $75,000. All remaining insurance benefits will be paid to your beneficiary when you die. This accelerated payment could provide much needed financial relief during a terminal illness when extra funds are needed. The accelerated benefits may be taxable. You should consult a professional tax advisor for specific information.

CONTINUING YOUR COVERAGE AFTER THE LEVEL TERM ENDS

At the end of your level term period, coverage will be continued under the group annual term plan, with premiums adjusted based on 5-year age bands, and you may keep the coverage through age 75. Your coverage amount will not reduce during your level term period. If you are under age 65 at the end of a level term period, coverage will not reduce until age 65. Coverage will reduce to 50% at age 65, to the lesser of 25% of the original face amount or 25,000 at age 70, and terminate at age 75.

If you are age 65 to 70 at the end of a level term period, coverage will reduce to 50%, and thereafter to the lesser of 25% of the original face amount or 25,000 at age 70. If you are age 70 to 75 at the end of a level term period, coverage will reduce to the lesser of 25% or 25,000 and terminate at age 75.

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AVAILABLE

This plan offers up to $500,000 of optional AD&D coverage to help with the added expenses that often occur with a sudden, unexpected accident. The AD&D benefit pays your beneficiary an additional amount if you die in a covered accident. In addition, if you are dismembered or lose your sight in a covered accident, you will receive a portion of your coverage, depending on the accident's severity.

SAVE MORE IF YOU QUALIFY AS "SUPER PREFERRED NON-TOBACCO"

Non-tobacco users applying for $200,000 of coverage or higher and meeting the highest underwriting standards may qualify as "Super Preferred Non-Tobacco," the plan's best rates. Other non-tobacco users that are approved for coverage will qualify for "Preferred Non-Tobacco" rates.

Group Term Life Application for 10-Year or 20-Year Level Term Rate

THE FLORIDA BAR

Please complete the entire application. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to* ***Member Benefits, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256.***
Phone 800-282-8626; Fax 904-396-2091

The Florida Bar (Association Insurance Trust) **Policy No. 29857-3**

1. TELL US ABOUT YOURSELF

Member/Employee's Information ***(complete this section only if applying for Member/Employee coverage on this application)*****:**

Name (Last, First, M.I.) ❑ Association Member ❑ Employee of Member		Name of Member	Member #
❑ Male ❑ Female	Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number
Address		City / State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Spouse of Member's Information ***(complete this section only if applying for Spouse of Member coverage on this application)*****:**

Name (Last, First, M.I.)		Name of Member	Member #
❑ Male ❑ Female	Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number
Address		City / State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Dependent Child(ren)'s Information ***(complete this section only if applying for Dependent Child(ren) on this application)*****:**

Number of eligiblechildren:_____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____
Name_____ DOB_____ SSN_____

Address	City	State	Zip	Home/Cell Phone #

	Member/Employee	**Spouse**
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?	❑ Yes ❑ No	❑ Yes ❑ No
Date of last use (month/year):	_____/_____	_____/_____
b) Are you currently working less than 30 hours per week at your regular occupation and place of business?	❑ Yes ❑ No	❑ Yes ❑ No
c) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	❑ Yes ❑ No	❑ Yes ❑ No

If yes, please explain:_____

2. SELECT YOUR COVERAGE

Member Amount	**Spouse of Member Amount**	**Employee of Member Amount**
❑ **10-Year Level Term**	❑ **10-Year Level Term**	❑ **10-Year Level Term**
❑ **20-Year Level Term**	❑ **20-Year Level Term**	❑ **20-Year Level Term**
❑ Other: $_____ *in $5,000 increments (Minimum: $200,000 Maximum: $1,000,000)*	❑ Other: $_____ *in $5,000 increments (Minimum: $200,000 Maximum: $500,000)*	❑ Other: $_____ *in $5,000 increments (Minimum: $200,000 Maximum: $250,000)*

Please select if you wish to include additional options with your coverage ***(If AD&D is elected, benefit will match life amount to a maximum of $600,000 for member, $500,000 for spouse and $250,000 for employee):***

❑ $10,000 Dependent Child(ren) Coverage*

❑ Member/Employee Accidental Death & Dismemberment

❑ Spouse of Member Accidental Death & Dismemberment

* If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION

Member/Employee: **Height_____ft. _____in. Weight_____lbs.** Spouse of Member: **Height_____ft. _____in. Weight_____lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member/Employee:_____ Spouse of Member:_____

_____ _____

		Member/Employee	**Spouse**
1)	Have you tested positive for exposure to the HIV infection or been diagnosed by a member of the medical profession as having AIDS or ARC caused by the HIV infection or other sickness or condition derived from such infection? ……...	❑ Yes ❑ No	❑ Yes ❑ No
2)	Have you ever been diagnosed or treated by a member of the medical profession for:		
	a. stroke/TIA (Transient Ischemic Attack) , sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?……..	❑ Yes ❑ No	❑ Yes ❑ No
	b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?……..	❑ Yes ❑ No	❑ Yes ❑ No
	c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?……..…	❑ Yes ❑ No	❑ Yes ❑ No
	d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?..	❑ Yes ❑ No	❑ Yes ❑ No
	e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?..	❑ Yes ❑ No	❑ Yes ❑ No
3)	Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?.....	❑ Yes ❑ No	❑ Yes ❑ No
4)	To the best of your knowledge, have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?	❑ Yes ❑ No	❑ Yes ❑ No
5)	Have you in the last three years flown, or do you anticipate flying in an aircraft within the next two years, other than as a passenger on a scheduled airline?	❑ Yes ❑ No	❑ Yes ❑ No
6)	Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations? …….....	❑ Yes ❑ No	❑ Yes ❑ No
	a. Member/Employee's driver's license number and state of issue:_____		
	b. Spouse of Member's driver's license number and state of issue:_____		
7)	Have you ever applied for insurance that was declined, postponed or modified in any way?.....	❑ Yes ❑ No	❑ Yes ❑ No
8)	Do you currently have any disorder, condition or disease diagnosed or treated by a member of the medical profession, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above? ……	❑ Yes ❑ No	❑ Yes ❑ No

For every "Yes" answer to questions in the previous section, give details below. Exclude any additional information regarding treatment for HIV/AIDS/ARC. Please attach a separate sheet if additional space is needed.

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	❑ Member/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				

PLEASE COMPLETE AND SIGN END OF APPLICATION

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Member/Employee Coverage ***(complete this section only if applying for Member/Employee coverage on this application)***

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Beneficiary for Spouse of Member Coverage ***(complete this section only if applying for Spouse of Member coverage on this application)***

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

5. SELECT PAYMENT METHOD

***(Choose only one. Option selected is applicable to all coverages approved through this application)*:**

☐ **Monthly Auto-Pay. I have included a VOID check and completed the Authorization below.**

Upon approval of my application by ReliaStar Life, I hereby authorize Member Benefits to initiate debit and credit entries to my Checking account and the Financial Institution named below to debit and/or credit the same account. Member Benefits will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid within the payment Grace Period. I acknowledge that the origination of ACH transactions to m y account must comply with the provisions of U.S. law. Service fees, when applicable by law, may apply for ACH debit returns, Member Benefits and my Bank may discontinue this service. This authority is to remain in full force and effective until Member Benefits has received written notice from me of its termination in such time and manner as to afford Member Benefits and the Financial Institution a reasonable opportunity to act on it.

X_____ ___/___/_____ _____

Accountholder's Signature Date Name of Financial Institution

☐ **Annual Direct Bill. Send No Money Now!**

If you select this method, and are approved for coverage, you will receive an initial invoice along with your certificate of insurance, for the required premium to pay your coverage through the end of the group plan year (Dec. 31st). After you pay your initial invoice, you will be invoiced for your full annual premium due January 1st each group plan year.

PLEASE COMPLETE AND SIGN END OF APPLICATION

6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have 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 Insurance Company.

Authorization and Acknowledgment – Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, pharmacy prescriptions or prescription records or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

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

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Member/Employee's Signature	Date	Spouse of Member's Signature (if applying)	Date

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

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

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. 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, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and 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. You can request that the agency interview you in connection with the preparation of the report. 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 us. 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; or your state's Insurance Information and Privacy Protection Act, if any. 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. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

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

Information Maintenance and Disclosure

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

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.