MOAA GROUP JOINT TERM LIFE APPLICATION

096342020505 04072-Q

The proposed insureds should complete the entire application. Please print clearly in dark ink.

Military Officers Association of America | Policy No. 68656-5

1 TELL US ABOUT YOURSELF:

Member's Information:

Name (Last, First, M.I.)	MOAA Member #	Rank/Service	☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	ZIP
Home/Cell Phone #	Work Phone #	Email Address	

Spouse's Information

Name (Last, First, M.I.)			☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Home/Cell Phone #	Work Phone #	Email Address	

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

Number of eligible children:_____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below				
Name	DOB	SSN		
Name	DOB	SSN		
Name	DOB	SSN		
Address	City	State	ZIP	Home/Cell Phone #

	Member YES	Member NO	Spouse YES	Spouse NO
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 12 months?.....	☐	☐	☐	☐
b) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?.....	☐	☐	☐	☐

If yes, please explain:_____

2 SELECT YOUR COVERAGE: *($10,000 minimum up to $350,000 maximum, depending on age, in $5,000 increments)*

Member/Spouse Amount

☐ $50,000 (_0N1) ☐ $100,000 (_0Y1) ☐ $_____ other

Dependent Child(ren) Coverage

☐ $10,000 (N0E7)

The Joint Term Life benefits will be paid to the surviving spouse. If you would like to designate a different beneficiary, please complete below. Beneficiary for dependent child(ren) coverage (if elected) will be the member.

_____
(Beneficiary Name) (Address)

_____
(Social Security Number) (D.O.B. MM/DD/YYYY) (Home/Cell Phone#) (Relationship)

3 PROVIDE YOUR HEALTH INFORMATION:

Member: **Height**_____**ft.** _____**in. Weight**_____**lbs.** Spouse: **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:_____ Spouse: _____

_____ _____

3 *Continued*

	Member YES	Member NO	Spouse YES	Spouse NO
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	☐	☐	☐	☐

A "yes" answer to the following questions alone will not automatically disqualify you for coverage. You will be asked to provide further information with respect to "yes" answers below.

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?	☐	☐	☐	☐
b. Cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?	☐	☐	☐	☐
c. Seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?	☐	☐	☐	☐
d. Arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?	☐	☐	☐	☐
e. Disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?	☐	☐	☐	☐
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?	☐	☐	☐	☐
4) Have you ever applied for insurance that was declined, postponed or modified in any way?	☐	☐	☐	☐
5) Do you currently have any disorder, condition or disease, 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?	☐	☐	☐	☐

For every "Yes" to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question #	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				
	☐ Member ☐ Spouse				

4 *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 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 or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its agents and employees 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 non-medical information, regarding motor vehicle or criminal 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. Upon your request, you may be interviewed in connection with the preparation of the report and receive a copy of the report.

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 Code of Federal Regulations Part 2. I may revoke this authorization as it applies to any information protected by 42 Code of Federal Regulations 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 and any company that controls, is controlled by, or is under common control with ReliaStar Life ("ReliaStar Life Affiliate") 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 any ReliaStar Life Affiliate.

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 or my authorized representative 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 that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who, with the 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 may have violated the state law.

I hereby certify that I am a current member of MOAA or plan to enroll/accept membership in MOAA and I acknowledge that I will receive e-communications from MOAA.

Member's Signature X _____ **Date** X _____
(always required)

Spouse's Signature X _____ **Date** X _____
(always required)

Don't send money now!

Mail your completed Application to:

MOAA Insurance Plans • P.O. Box 14464 • Des Moines, IA 50306 • **Questions?** Call Toll-Free **1-800-247-2192**

(Hearing-impaired or voice-impaired members may call the Relay Line at 711-800-247-2192.)

Or, email moaa.service@mercer.com