



MOAA Group Term Life Application for 10-Year or 15-Year or 20-Year Level Term Life Insurance

096342020202

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

Military Officers Association of America Policy No. 68653-1 (10yr), 68654-9 (15yr), 68655-7 (20yr)

1 TELL US ABOUT YOURSELF:

Member's Information:

Name (Last, First, M.I.)		MOAA Member #	Rank/Service	<input type="checkbox"/> Male <input type="checkbox"/> 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 (complete this section if applying for Spouse coverage on this application):

Name (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number
Home/Cell Phone #	Work Phone #	Email Address

		Member	Spouse
		YES	NO
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?.....		<input type="checkbox"/>	<input type="checkbox"/>
Date of last use (month/year):	/	/	/
b) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?.....		<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____			

2 SELECT YOUR COVERAGE: (\$10,000 minimum up to \$500,000 maximum, depending on age, in \$5,000 increments) For 10-year, must be under age 70; 15-year, under age 66; 20-year, under age 61.

10-Year Level Term (04024-Q)		15-Year Level Term (04044-Q)		20-Year Level Term (04064-Q)	
Member	Spouse	Member	Spouse	Member	Spouse
<input type="checkbox"/> \$50,000 (L0N1)	<input type="checkbox"/> \$50,000 (L0N5)	<input type="checkbox"/> \$50,000 (L0N1)	<input type="checkbox"/> \$50,000 (L0N5)	<input type="checkbox"/> \$50,000 (L0N1)	<input type="checkbox"/> \$50,000 (L0N5)
<input type="checkbox"/> \$100,000 (L0Y1)	<input type="checkbox"/> \$100,000 (L0Y5)	<input type="checkbox"/> \$100,000 (L0Y1)	<input type="checkbox"/> \$100,000 (L0Y5)	<input type="checkbox"/> \$100,000 (L0Y1)	<input type="checkbox"/> \$100,000 (L0Y5)
<input type="checkbox"/> \$ _____ Other	<input type="checkbox"/> \$ _____ Other	<input type="checkbox"/> \$ _____ Other	<input type="checkbox"/> \$ _____ Other	<input type="checkbox"/> \$ _____ Other	<input type="checkbox"/> \$ _____ Other

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: _____

		Member	Spouse
		YES	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)?		<input type="checkbox"/>	<input type="checkbox"/>
A "yes" answer to the following questions alone will not automatically disqualify you for coverage. You may 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?		<input type="checkbox"/>	<input type="checkbox"/>
b. Cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?		<input type="checkbox"/>	<input type="checkbox"/>
c. Seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?		<input type="checkbox"/>	<input type="checkbox"/>
d. Arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?		<input type="checkbox"/>	<input type="checkbox"/>
e. Disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?		<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever applied for insurance that was declined, postponed or modified in any way?		<input type="checkbox"/>	<input type="checkbox"/>

3 Continued

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|---|--------------------------|--------------------------|
| | Member | Spouse |
| | YES | NO |
| 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?.... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Have you in the last 3 years flown as a private pilot, passenger in a private plane, or do you anticipate participation in private aviation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Please provide:
a. Member's driver's license number and state of issue: _____
b. Spouse's driver's license number and state of issue: _____ | | |

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
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				

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. Attach additional sheets if necessary.

Beneficiary for Member Coverage (complete this section if applying for Member coverage on this application):

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

Beneficiary for Spouse Coverage (complete this section if applying for Spouse coverage on this application):

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

5 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 _____ (always required) Spouse's Signature X _____ (if applying)	Date X _____ Date X _____
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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