

SERFF Tracking Number: INGD-126167275 State: Arkansas
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 42558
Company Tracking Number: 153793
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: General and Variable Account Individual Life Insurance Application
Project Name/Number: General and Variable Account Individual Life Insurance Application/153793

Filing at a Glance

Company: ReliaStar Life Insurance Company

Product Name: General and Variable Account Individual Life Insurance Application
SERFF Tr Num: INGD-126167275 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-Closed
State Tr Num: 42558

Sub-TOI: L08.000 Life - Other

Co Tr Num: 153793

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Wendy Paquin, Terry Stumpf, Jackie Williams, EDS

Disposition Date: 06/08/2009

EDSSupport, Laura Sampair

Date Submitted: 06/02/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: General and Variable Account Individual Life Insurance Application
Status of Filing in Domicile: Pending

Project Number: 153793

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: ReliaStar Life Insurance Company's domicile is Minnesota and it is included as a member state in our Interstate Insurance Compact filing of these forms.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/08/2009

Explanation for Other Group Market Type:

State Status Changed: 06/08/2009

Deemer Date:

Created By: Laura Sampair

Submitted By: Laura Sampair

Corresponding Filing Tracking Number:

Filing Description:

SERFF Tracking Number: INGD-126167275 State: Arkansas
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 42558
Company Tracking Number: 153793
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: General and Variable Account Individual Life Insurance Application
Project Name/Number: General and Variable Account Individual Life Insurance Application/153793

Insurance Commissioner
Department of Insurance
Compliance Life & Health
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: ReliaStar Life Insurance Company
NAIC #67105 FEIN #41-0451140

Form Numbers:

153793 Individual Life Insurance Application
153808 Individual Life Insurance Application Part II - Medical Declarations
153795 Individual Life Insurance Application Part II - Medical Examination
153794 Temporary Insurance Receipt
153796 Children's Insurance Rider Application
153813 Amendment to Application
153849 Additional Statement to Application
153836 Supplement to Individual Life Insurance Application - Alcohol Usage Questionnaire
153837 Supplement to Individual Life Insurance Application - Aviation Questionnaire
153838 Supplement to Individual Life Insurance Application - Drug Usage Questionnaire
153839 Supplement to Individual Life Insurance Application - Foreign Travel or Residence Questionnaire
153840 Supplement to Individual Life Insurance Application - Military Questionnaire
153841 Supplement to Individual Life Insurance Application - Motor Sports Questionnaire
153842 Supplement to Individual Life Insurance Application - Scuba Diving Questionnaire
153843 Supplement to Individual Life Insurance Application - Tobacco/Nicotine Use Questionnaire
153844 Supplement to Individual Life Insurance Application - Avocations and Professional Sports Questionnaire

Attention Policy Form Approval Division:

We submit the above referenced forms for your review and approval.

These forms will be available both in a printed and electronic format. The electronic format application presented to the customer for signature will appear on screen as a pdf of the filed application form containing all information completed by the customer, in appearance identical to the printed version. If an electronic signature will be used with an application, it will be obtained in compliance with applicable State and Federal law.

These forms are new and do not contain any unusual or controversial items from the standpoint of industry standards.

SERFF Tracking Number: *INGD-126167275* State: *Arkansas*
Filing Company: *ReliaStar Life Insurance Company* State Tracking Number: *42558*
Company Tracking Number: *153793*
TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
Product Name: *General and Variable Account Individual Life Insurance Application*
Project Name/Number: *General and Variable Account Individual Life Insurance Application/153793*

We have simultaneously filed the forms in Minnesota, our state of domicile, under an Interstate Insurance Compact filing.

Please note we are submitting this filing simultaneously for Security Life of Denver Insurance Company.

153793 Individual Life Insurance Application - This form will be used by licensed agents in the solicitation to the general public of our general account and variable account individual life insurance products.

153808 Individual Life Insurance Application Part II - Medical Declarations – This form will be used when the proposed insured is not completing Part II - Medical Examination.

153795 Individual Life Insurance Application Part II - Medical Examination – This form will be used when the proposed insured completes the Part II medical information with a medical examiner.

153794 Temporary Insurance Receipt - This form will be used to provide the propose insured(s) with a temporary insurance receipt once Part I of the Application has been completed, a premium accepted and this form completed and signed.

153796 Children's Insurance Rider Application – This form will be used by the proposed Insured under the base policy to apply for insurance coverage on their child or children under a Children's Insurance Rider.

153813 Amendment to Application – This form will be used to incorporate additional clarifying or corrected information to the completed and executed application and/or medical examination forms. The form will never be used without having previously received a completed and signed application to which it will attach. This form will never be used alone. The information bracketed on the attached Amendment to Application form is subject to change. The administrative system will put in the correct form (“Application” or “Medical Exam”) which is being amended in the first two bracketed phrases of the Amendment form. The bracketed sentence will be typed in by a customer service representative who will also insert the section/question number(s) that are being updated.

153849 Additional Statement to Application – This form will be used to update the original application when an item completed in the original application has changed prior to policy approval and issue. It will also be used to update the original application for a proposed insured up to age 80 if the original application is dated between 90 days and 6 months prior to approval and issue, and for a proposed insured age 81 and older if the original application is dated between 30 days and 3 months prior to approval and issue. The form will never be used without having previously received a completed and signed application to which it will attach. This form will never be used alone.

153836 Supplement to Individual Life Insurance Application - Alcohol Usage Questionnaire – This form will be used to assess risk based on alcohol usage.

SERFF Tracking Number: *INGD-126167275* State: *Arkansas*
Filing Company: *ReliaStar Life Insurance Company* State Tracking Number: *42558*
Company Tracking Number: *153793*
TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
Product Name: *General and Variable Account Individual Life Insurance Application*
Project Name/Number: *General and Variable Account Individual Life Insurance Application/153793*

153837 Supplement to Individual Life Insurance Application - Aviation Questionnaire - This form will be used to evaluate the proposed insured's suitability for insurance when he/she flies other than as a passenger on a commercial airline.

153838 Supplement to Individual Life Insurance Application - Drug Usage Questionnaire - This form will be used to assess risk based on drug usage.

153839 Supplement to Individual Life Insurance Application - Foreign Travel or Residence Questionnaire - This form will be used to assess risk when the proposed insured engages in foreign travel or is not a U.S. Citizen.

153840 Supplement to Individual Life Insurance Application - Military Questionnaire - This form will be used when the proposed insured is a member of the Armed Forces.

153841 Supplement to Individual Life Insurance Application - Motor Sports Questionnaire - This form will be used to assess risk when the proposed insured engages in motor sports activities.

153842 Supplement to Individual Life Insurance Application - Scuba Diving Questionnaire - This form will be used to assess risk when the proposed insured engages in scuba diving.

153843 Supplement to Individual Life Insurance Application - Tobacco/Nicotine Use Questionnaire - This form will be used to evaluate proposed insured's suitability for insurance when he/she uses tobacco and other nicotine products.

153844 Supplement to Individual Life Insurance Application - Avocations and Professional Sports Questionnaire - This form will be used to assess risk when the proposed insured engages in hazardous activities and/or professional sports.

We hereby certify that we are in compliance with Arkansas Code Ann. 23-79-138 and Regulation 49.

We have enclosed a Flesch Readability Certification for the forms.

Unless otherwise informed, we reserve the right to alter the layout of the enclosed forms, including sequential ordering of the sections, color, and type font and size, and any changes necessary to comply with your state requirements, but we will only do so if such changes are within the allowable parameters or requirements set forth in your statutes.

To the best of our knowledge, the forms comply with the laws and regulations of the insurance department of your state.

Sincerely,

Laura Sampair, FLMI, FFSI, PCS, AAPA, AIAA, AIRC, ARA
Contract Analyst

SERFF Tracking Number: INGD-126167275 State: Arkansas
 Filing Company: ReliaStar Life Insurance Company State Tracking Number: 42558
 Company Tracking Number: 153793
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: General and Variable Account Individual Life Insurance Application
 Project Name/Number: General and Variable Account Individual Life Insurance Application/153793
 (612) 342-7081
 (612) 342-7531 (fax)
 laura.sampair@us.ing.com

Company and Contact

Filing Contact Information

Laura Sampair, laura.sampair@us.ing.com
 20 Washington Ave South 612-342-7081 [Phone]
 Minneapolis, MN 55401 612-342-7081 [FAX]

Filing Company Information

ReliaStar Life Insurance Company CoCode: 67105 State of Domicile: Minnesota
 20 Washington Avenue South Group Code: 229 Company Type:
 Minneapolis, MN 55401 Group Name: State ID Number:
 (860) 654-8065 ext. [Phone] FEIN Number: 41-0451140

Filing Fees

Fee Required? Yes
 Fee Amount: \$320.00
 Retaliatory? No
 Fee Explanation: (7 App's x \$20 per App) + (9 Questionnaires x \$20 per Questionnaire) = \$320
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ReliaStar Life Insurance Company	\$320.00	06/02/2009	28262344

SERFF Tracking Number: *INGD-126167275* State: *Arkansas*
Filing Company: *ReliaStar Life Insurance Company* State Tracking Number: *42558*
Company Tracking Number: *153793*
TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
Product Name: *General and Variable Account Individual Life Insurance Application*
Project Name/Number: *General and Variable Account Individual Life Insurance Application/153793*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/08/2009	06/08/2009

SERFF Tracking Number: *INGD-126167275* *State:* *Arkansas*
Filing Company: *ReliaStar Life Insurance Company* *State Tracking Number:* *42558*
Company Tracking Number: *153793*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *General and Variable Account Individual Life Insurance Application*
Project Name/Number: *General and Variable Account Individual Life Insurance Application/153793*

Disposition

Disposition Date: 06/08/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: INGD-126167275 State: Arkansas
 Filing Company: ReliaStar Life Insurance Company State Tracking Number: 42558
 Company Tracking Number: 153793
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: General and Variable Account Individual Life Insurance Application
 Project Name/Number: General and Variable Account Individual Life Insurance Application/153793

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Individual Life Insurance Application		Yes
Form	Individual Life Insurance Application Part II - Medical Declarations		Yes
Form	Individual Life Insurance Application Part II - Medical Examination		Yes
Form	Temporary Insurance Receipt		Yes
Form	Children's Insurance Rider Application		Yes
Form	Amendment to Application		Yes
Form	Additional Statement to Application		Yes
Form	Supplement to Individual Life Insurance Application - Alcohol Usage Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Aviation Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Drug Usage Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Foreign Travel or Residence Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Military Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Motor Sports Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Scuba Diving Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Tobacco/Nicotine Use Questionnaire		Yes
Form	Supplement to Individual Life Insurance Application - Avocations and Professional Sports Questionnaire		Yes

SERFF Tracking Number: INGD-126167275 State: Arkansas
 Filing Company: ReliaStar Life Insurance Company State Tracking Number: 42558
 Company Tracking Number: 153793
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: General and Variable Account Individual Life Insurance Application
 Project Name/Number: General and Variable Account Individual Life Insurance Application/153793

Form Schedule

Lead Form Number: 153793

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	153793	Application/ Individual Life Enrollment Insurance Application Form	Initial		50.500	153793_0529 2009_StateFiled.pdf
	153808	Application/ Individual Life Enrollment Insurance Application Form Part II - Medical Declarations	Initial		70.600	153808_0529 2009_StateFiled.pdf
	153795	Application/ Individual Life Enrollment Insurance Application Form Part II - Medical Examination	Initial		50.800	153795_0521 2009_StateFiled.pdf
	153794	Application/ Temporary Insurance Enrollment Receipt Form	Initial		51.900	153794_0529 2009_StateFiled.pdf
	153796	Application/ Children's Insurance Enrollment Rider Application Form	Initial		51.700	153796_0522 2009_StateFiled.pdf
	153813	Application/ Amendment to Enrollment Application Form	Initial		59.400	153813 (Final).pdf
	153849	Application/ Additional Statement Enrollment to Application Form	Initial		57.200	153849 (Final).pdf
	153836	Application/ Supplement to Enrollment Individual Life Form Insurance Application - Alcohol Usage Questionnaire	Initial		53.200	153836_0521 2009.pdf
	153837	Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial		50.800	153837_0521 2009.pdf

SERFF Tracking Number: INGD-126167275 State: Arkansas
 Filing Company: ReliaStar Life Insurance Company State Tracking Number: 42558
 Company Tracking Number: 153793
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: General and Variable Account Individual Life Insurance Application
 Project Name/Number: General and Variable Account Individual Life Insurance Application/153793

Project Number	Description	Initial	Value	File Name
153838	- Aviation Questionnaire Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial	54.100	153838_0521 2009.pdf
153839	- Drug Usage Questionnaire Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial	76.500	153839_0521 2009.pdf
153840	- Foreign Travel or Residence Questionnaire Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial	73.200	153840_0521 2009.pdf
153841	- Military Questionnaire Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial	61.300	153841_0521 2009.pdf
153842	- Motor Sports Questionnaire Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial	68.000	153842_0521 2009.pdf
153843	- Scuba Diving Questionnaire Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial	87.300	153843_0521 2009.pdf
153844	- Tobacco/Nicotine Use Questionnaire Application/ Supplement to Enrollment Individual Life Form Insurance Application	Initial	51.600	153844_0521 2009.pdf
	- Avocations and Professional Sports			

SERFF Tracking Number: *INGD-126167275* *State:* *Arkansas*
Filing Company: *ReliaStar Life Insurance Company* *State Tracking Number:* *42558*
Company Tracking Number: *153793*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *General and Variable Account Individual Life Insurance Application*
Project Name/Number: *General and Variable Account Individual Life Insurance Application/153793*

Questionnaire

INDIVIDUAL LIFE INSURANCE APPLICATION

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401

Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203

A member of the ING family of companies ("the Company")

PART I - A. PRODUCT INFORMATION

1. Product Requested _____ 2. Product Type: General Account Variable Account

If applying for a variable life insurance policy, the proposed owner must receive a current prospectus and complete the Fund Allocation of Premium Payments form. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS AND THE CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNTS. AN ILLUSTRATION OF BENEFITS, INCLUDING DEATH BENEFITS, POLICY VALUES AND CASH VALUES, IS AVAILABLE UPON REQUEST.

3. Base Coverage: \$ _____ (Not including Term Riders - See Section B for Adjustable Term Insurance Rider.)

4. Death Benefit Option: (If no option is selected, option will default to A.)

- A or 1 - Level B or 2 - Increasing or Variable
C or 3 - Face Amount + Premium D or 4 - Face Amount + Premium + Interest %

5. Death Benefit Qualification Test: (If no option is selected, option will default to Guideline Premium Test.)

- Guideline Premium Test Cash Value Accumulation Test

6. Is the insurance employer-sponsored? Yes No

7. List all applications that are concurrently being submitted to ING for the Insured's family members and/or business partners.

Company Name _____ Amount \$ _____

Company Name _____ Amount \$ _____

If the policy will be owned by a "Funded ERISA Plan", complete question 8, specify the plan and trust type and provide the other information requested.

8. Is the insurance for a tax-qualified, pension, profit sharing or defined contribution ERISA plan, or a VEBA or welfare benefit arrangement? Yes No

Plan Provider Name _____

Tax-qualified plan (specify profit sharing, defined benefit, or defined contribution) _____

Section 419/419A(f)(6) welfare benefit or VEBA plan Other (specify type and name of plan) _____

PART I - B. RIDER INFORMATION (Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)

Signed illustration is required for permanent products.

- Accidental Death Benefit Rider \$ _____
Additional Insured Rider (Complete Part I - D.) \$ _____
Adjustable Term Insurance Rider (Specify Target Death Benefit) \$ _____
Children's Insurance Rider (Complete Children's Insurance Rider Application.)
Guaranteed Death Benefit Rider (An option below must be selected.)
Lifetime 20-Year To age 65 or 20 years, if later
Guaranteed Minimum Accumulation Benefit Rider

- Waiver of Cost of Insurance Rider
Waiver of Monthly Deduction Rider
Waiver of Premium (Term only)
Waiver of Specified Premium Total Disability Rider (Specify monthly premium - illustration required) \$ _____
Waiver of Surrender Charge Rider
Other
Other
Other

PART I - C. PROPOSED PRIMARY INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____

2. Birth Date _____ SSN _____ Birth State/Country _____ Gender: M F

3. Residence Address (PO Boxes are not permitted.) _____

City _____ State _____ ZIP _____

4. Daytime Phone (_____) _____ Evening Phone (_____) _____

5. Best Time to Call _____ E-mail _____

6. Are you a U.S. Citizen? (If "No", complete the Foreign Travel and Residence Questionnaire.) Yes No

7. Occupation/Duties _____

8. Employer _____ Phone (_____) _____

PART I - C. PROPOSED PRIMARY INSURED INFORMATION (CONTINUED)

- 9. Employer Address _____
- 10. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches) Yes No
If "Yes", indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____
- 11. Driver's License Number _____ 12. Driver's License State _____
(If you do not have a driver's license, then provide government photo ID #, issuer and expiration date.)
- 13. Name on Driver's License (if different than above) _____

PART I - D. PROPOSED OTHER INSURED INFORMATION

- 1. First Name _____ MI _____ Last Name _____
- 2. Birth Date _____ SSN _____ Birth State/Country _____ Gender: M F
- 3. Residence Address (PO Boxes are not permitted.) _____
City _____ State _____ ZIP _____
- 4. Daytime Phone (_____) _____ Evening Phone (_____) _____
- 5. Best Time to Call _____ E-mail _____
- 6. Are you a U.S. Citizen? (If "No", complete the Foreign Travel and Residence Questionnaire.) Yes No
- 7. Occupation/Duties _____
- 8. Employer _____ Phone (_____) _____
- 9. Employer Address _____
- 10. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches) Yes No
If "Yes", indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____
- 11. Driver's License Number _____ 12. Driver's License State _____
(If you do not have a driver's license, then provide government photo ID #, issuer and expiration date.)
- 13. Name on Driver's License (if different than above) _____

PART I - E. PROPOSED OWNER/TRUST/CORPORATION INFORMATION (If Proposed Owner is a Trust or Corporation, provide first and last pages of the Trust document, including signatures. The Trust must be established prior to the application date.)

- 1. Full Name of Owner/Trust/Corporation (30 character limit) _____
- 2. Owner Relationship to Proposed Primary Insured _____
- 3. Owner Birth Date _____ Owner Phone (_____) _____ Owner SSN/TIN _____
- 4. Owner Address (PO Boxes are not permitted.) _____
City _____ State _____ ZIP _____
- 5. Corporation Contact Name _____
- 6. Address of Trust/Corporation _____
- 7. Billing Address _____
- 8. Type of Government Issued ID (Driver's License/Passport) _____ Document Number _____
Issuing State or Country _____ Issuance Date _____ Expiration Date _____
- 9. Trust Contact Name _____ TIN _____ Trust Date _____
- 10. Purpose of the Trust _____ Type of Trust: Revocable Irrevocable
- 11. State of Incorporation _____ Trustee/Corporate Officer Name _____
- 12. 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 on the application.)

PART I - F. BENEFICIARY INFORMATION

Unless otherwise stated, the beneficiary designation is revocable and beneficiaries of like class shall share rights of survivorship equally. If Trust or Corporation, provide name and date of trust agreement and state of incorporation. Percentages must total 100%, using whole percentages only. If additional space is needed, use Section Q.

1. Is the Beneficiary a Trust? Yes No

2. Trust Name _____ Trust Date _____ State of Incorporation _____

	Name (First, MI, Last)	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
Proposed Primary Insured			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
Proposed Other Insured			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

PART I - G. PERSONAL HISTORY (Questions 1-7 must be completed for all Proposed Insureds.)

- | | | |
|--|--|--|
| | Proposed Insured | Proposed Other Insured |
| 1. Are you, or do you intend to become a member of the armed forces, including the Reserves, or on alert?
(If "Yes", complete Military Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you intend to travel or reside outside the United States or Canada in the next two years? (If "Yes", complete the Foreign Travel and Residence Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? (If "Yes", complete the Aviation Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, rodeos, or any other hazardous sports or activities?
(If "Yes", complete the appropriate questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes, dune buggies, etc.? (If "Yes", complete Avocations and Professional Sports Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Except for traffic violations, have you been convicted in a criminal proceeding or been the subject of a pending criminal proceeding? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For any "Yes" answer to questions 6-7, please record information in the chart below.

Question	Proposed Insured/Proposed Other Insured	Explanation

PART I - H. PAYMENT INFORMATION

- 1. Initial Payment: Check Cash on Delivery 1035 Exchange ING Internal or Affiliated Exchange/Surrender
- 2. Initial Payment Amount \$ _____ Planned/Scheduled/Modal Payment \$ _____
- 3. Frequency of Subsequent Payments: Annually Semi-Annually Quarterly Monthly¹
- Military Allotment² (Active or retired military members must complete the Military Allotment form and return it to the military finance department.)
- Civil Service Allotment (The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)

¹ Available with electronic funds transfer.
² Two monthly premium payments are required before the policy becomes active.

PART I - I. LIST BILL INFORMATION - EMPLOYER-SPONSORED PLANS ONLY (For a new List Bill Plan, please contact the List Bill Department at 877-886-5050.)

- 1. List Bill/File Code # (if plan already exists) _____
- 2. Employer Plan Name (if plan already exists) _____ 3. Phone _____
- 4. Address _____
- City _____ State _____ ZIP _____

PART I - J. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? Yes (If "Yes", review the policy backdating notice below.)

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

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.

I understand, on backdated policies, that the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

PART I - K. FINANCIAL DETAILS

- 1. Will the applicant accept this policy if it is a "Modified Endowment Contract" at issue? Yes No
- 2. Is the policy in accordance with your insurance objectives and your anticipated financial needs? Yes No
- 3. Do you believe you have the financial ability to continue making premium payments on this policy? Yes No
- 4. Have you or your company ever declared bankruptcy? (If "Yes", provide details including date discharged.) Yes No

5. Personal Insurance (For Personal Insurance complete questions 5-7; for Business Insurance complete questions 8-11.)

- Estate Liquidity Family Protection Tax Planning Retirement Planning Cash Accumulation
- Other _____

6.	Annual Earned Income	Annual Interest and Other Income
Proposed Primary Insured		
Proposed Other Insured		

7. Total Assets \$ _____ Total Liabilities \$ _____ Total Net Worth \$ _____

PART I - K. FINANCIAL DETAILS (CONTINUED)

8. Business Insurance: Buy/Sell Key Person Other _____

9. Total Business Assets \$ _____ Total Business Liabilities \$ _____ Total Business Net Worth \$ _____

10. Business Net Profit After Taxes for Past Two Years: Last Year \$ _____ Previous Year \$ _____

11. Owner Name	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?
		\$ _____	_____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ _____	_____ %	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART I - L. IN FORCE/REPLACEMENT INFORMATION (Questions 1-3 must be completed for each Proposed Insured/Other Insured/Owner.)

1. Do you currently have life insurance in force or applied for? (If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)

	Proposed Insured	Proposed Other Insured	Proposed Owner
	Yes No	Yes No	Yes No
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Insured Name	Insurance Company (Do not include group policies.)	Policy Number	Amount	Date Issued

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? (If "Yes", complete state required replacement form and provide details below.)

	Proposed Insured	Proposed Other Insured	Proposed Owner
	Yes No	Yes No	Yes No
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If "Yes", complete state required replacement form and provide details below.)

	Proposed Insured	Proposed Other Insured	Proposed Owner
	Yes No	Yes No	Yes No
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

4. For any "Yes" answer to questions 2-3, provide details regarding the policies being replaced in the chart below.

Insured Name	Insurance Company	Policy Number	Amount

5. Is this insurance intended to be a tax free or 1035 Exchange? (1035 not available on term insurance). Yes No

6. If "Yes", will a policy loan be carried over? Yes No

PART I - M. MEDICAL TRANSFER STATEMENT (Complete when submitting medical examinations of another insurance company.)

1. Insurance Company Name _____ 2. Examination Date _____

	Proposed Insured	Proposed Other Insured
	Yes No	Yes No
3. To the best of your knowledge and belief, are the statements in the examination true and complete today?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 1 above? (If "Yes", complete Part II - Medical Declarations.)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

PART I - N. SUITABILITY/NEEDS ANALYSIS - VARIABLE PRODUCTS ONLY (Completed by the Proposed Owner. Failing to provide this information will result in a delay in the issuing of new business.)

1. Have you received a current prospectus including supplements for the variable life insurance policy? Yes No
Provide date of policy prospectus/supplement _____
2. Do you understand that:
- a. The amount or duration of the policy death benefit may vary under specified conditions; **Policy values may increase or decrease with the investment experience of the variable investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division and/or the Indexed Credit Strategy, if applicable; The amount payable is not guaranteed, but is dependent on the account value and amounts owed under the policy?** Yes No
 - b. The fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? Yes No
 - c. Personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience of the variable investment options or of actual interest credited in the general account option(s)? Yes No

PART I - O. TELEPHONE PRIVILEGES - INDEXED AND VARIABLE PRODUCTS ONLY

I understand that I may indicate below whether to allow telephone privileges to be provided to me and/or my agent/registered representative and his/her assistant. Telephone privileges allow an authorized person to call the Company to make certain elections and request certain transactions. The Company may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. By accepting telephone privileges, I authorize the Company to record my telephone calls to the Company. The Company and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be genuine.

I understand that if I do not want to authorize telephone privileges, I should not check either of the two boxes below. I also understand that once granted, such privileges will be revoked by upon receipt by the Company of signed, written instructions to terminate telephone privileges.

- I want telephone privileges.
- I want telephone privileges granted to my agent/registered representative and his/her assistant.

PART I - P. REPLACEMENT VERIFICATION (For Agent use ONLY)

1. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? (If "Yes", submit state required replacement forms.) Yes No
- a. Is the applicant considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating their existing policy or contract? (If "Yes", complete state required replacement form and provide details below.) Yes No
 - b. Is the applicant considering using funds from their existing policies or contracts to pay premiums due on the new policy or contract? (If "Yes", complete state required replacement form.) Yes No
- Company _____ Policy Number _____ Amount \$ _____

PART I - Q. NOTES

Use this space to provide any additional details to questions answered throughout the application. Please understand that if you provide the Company with information on this page it will be considered part of your Individual Life Insurance Application.

Section	Question	Details

PART I - R. ING'S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI)

As established leaders in the financial services industry, the Company along with other ING Life Companies strongly opposes arrangements designed to obtain life insurance for the benefit of a third party that lacks an insurable interest in the insured. We believe this position supports the best interests of our policy owners, as these stranger-owned or stranger-originated life insurance transactions ("STOLI") will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business.

To help prevent STOLI and protect our policy owners, we require that all parties confirm they have read and will abide by the Company's policy on STOLI arrangements. The Company will seek to rescind or cancel the insurance coverage of any contract where material misrepresentation occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

Company appointed producers are prohibited from selling any Company life insurance product and an applicant may not purchase a product in the following circumstances:

- If, at the time of sale, a plan exists to directly or indirectly sell, assign, settle or otherwise transfer the policy (or the rights to its death benefits), or an ownership or beneficial interest in an entity that will own the policy, to a life settlement company or other third party;
- If, in connection with the sale, the policy owner and/or insured is offered any consideration or inducement, including, but not limited to, cash payments, "free" or "no cost" insurance;

- Using a sales concept, design, marketing plan, marketing material or other program (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending) that has not been made available by the Company; or
- Where the producer and/or applicant knows, or has reason to know that the true source of funds (e.g., premium financing, third party funding) for premium payments of a policy have not been disclosed to the Company.

Company appointed producers are also prohibited from providing, or aiding and abetting the provision of, fraudulent or misleading answers to application or inspection questions, including, but not limited to, questions on the Agent Report section.

Participation in a Prohibited Practice May Result in Disciplinary Action to Producers.

Producers involved in any prohibited practice will be subject to contract and appointment termination, including termination for cause, which may include loss of all current and future commissions. The Company will also report cases of fraud and material misrepresentation to state fraud departments for investigation and potential regulatory action.

By my signature in Section S on this application, I affirmatively represent that I have read the Company's policy on STOLI arrangements set forth above, that I have not engaged in any prohibited conduct described above in connection with this application, and that I will abide by the policy on STOLI arrangements.

PART I - S. AUTHORIZATION AND ACKNOWLEDGEMENT

Verification. By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and declare that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. Unless otherwise stated in a Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, and the first premium is received by the Company while the Proposed Insured is alive. If I have paid premium with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

Statements of Understanding. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original. I give my permission to the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied.

I acknowledge receipt of the following disclosures and notices: Accelerated Benefit Rider and Critical Illness Disclosures, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. I certify, under penalty of perjury, that my Social Security Number/tax identification number is shown and is correct and that I am not subject to back-up withholding.

PART I - S. AUTHORIZATION AND ACKNOWLEDGEMENT (Continued)

If an investigative consumer report is prepared, I request to be interviewed. Yes No

Daytime phone number: () .
Contact me between the hours of ____ a.m./p.m. and ____ a.m./p.m.

By signing below I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:

Governing Law. The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

Jurisdiction. Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

All completed materials must be sent to the ING Customer Service Center at: 2000 21st Ave. NW, Minot, ND 58703

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

Proposed Owner Signed at (city/state) _____ Date _____

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

 Proposed Insured Signature _____ Date _____
(if other than the owner & age 15 or older)

 Proposed Other Insured Signature _____ Date _____

Proposed Owner/Trustee Name (please print) _____

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

 Writing Agent/Registered Rep. Signature _____ Date _____

Writing Agent State Lic. Number _____ Writing Agent/Registered Rep. Number _____

Agent/Registered Rep. Name _____

Agent State Lic. Number _____ Agent/Registered Rep. Number _____

Agent/Registered Rep. Name _____

Agent State Lic. Number _____ Agent/Registered Rep. Number _____

INDIVIDUAL LIFE INSURANCE APPLICATION PART II - MEDICAL DECLARATIONS

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
 A member of the ING family of companies



For any proposed insured not completing a separate Part II Medical Examination, questions 1-16 below must be completed. Provide names and other data of Proposed Insured and all Proposed Other Insureds.

Proposed Primary Insured

1. Height _____ Weight _____ Loss or gain in pounds during the last year _____
2. Personal Physician Name _____ Physician Phone (_____) _____
3. Physician Address _____ City _____ State _____ ZIP _____
4. Date last seen by Physician _____ 5. Reason for Consultation _____
6. Results of Consultation _____

Proposed Other Insured

7. Height _____ Weight _____ Loss or gain in pounds during the last year _____
8. Personal Physician Name _____ Physician Phone (_____) _____
9. Physician Address _____ City _____ State _____ ZIP _____
10. Date last seen by physician _____ 11. Reason for Consultation _____
12. Results of Consultation _____

	Proposed Insured	Proposed Other Insured
13. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:		
a. Dizziness, seizures, convulsions, headache, paralysis, stroke, TIA, or a mental or nervous disorder, including anxiety or depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or other disorder of the stomach, intestine, liver, pancreas, or gall bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or other disorder of the kidneys, bladder, breasts, prostate, or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes, thyroid, or other endocrine disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Disorder of the skin or lymph glands, arthritis, or any disorder of the muscles, joints, nerves or bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Anemia or any other disorder of the blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. A positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you:		
a. Experienced any symptom(s) for which you have not yet consulted a health care provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Had any operation(s) in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. In the past 5 years been advised to have operation(s), treatments, or diagnostic tests that have not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? (If "Yes", complete Alcohol Usage or Drug Use Questionnaire.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. In the past 5 years been confined for observation, care, or treatment in a hospital or other health care facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. In the past 5 years consulted any health care provider(s), not already identified, for any reason including routine physical examination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are you:		
a. Presently taking any medication(s), including non-prescription/over the counter medication or supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? (If "Yes", complete Drug Use Questionnaire.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

For any "Yes" answer to questions 13-15 please record information in chart below.

Question	Person	Condition/Diagnosis	Dates/Duration of Condition/Treatment	Physician Name	Physician Address

16. Family History							
Proposed Insured				Proposed Other Insured			
	Age if Living	Age at Death	Present Health or Cause of Death		Age if Living	Age at Death	Present Health or Cause of Death
Father				Father			
Mother				Mother			
Brother(s)				Brother(s)			
Sister(s)				Sister(s)			

I have read the statements above and affirm that they are complete and true to the best of my knowledge and belief.

Signed at (city, state) _____ Date _____

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

 Proposed Other Insured Signature _____ Date _____

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

INDIVIDUAL LIFE INSURANCE APPLICATION PART II - MEDICAL EXAMINATION

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
 ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



1. Proposed Insured Name _____ Birth Date _____ SSN _____

2. Personal Physician or Clinic Name _____ Phone Number _____

3. Personal Physician or Clinic Address _____

City _____ State _____ ZIP _____

4. Date last seen by Physician _____ Reason for Consultation _____

5. Consultation Results _____

6. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:

- a. Dizziness, seizures, convulsions, headaches, paralysis, stroke, TIA, or a mental or nervous disorder, including anxiety or depression? Yes No
- b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder? Yes No
- c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or any other disorder of the heart or blood vessels? Yes No
- d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or any other disorder of the stomach, intestine, liver, pancreas, or gall bladder? Yes No
- e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or any other disorder of the kidney, bladder, breasts, prostate, or reproductive organs? Yes No
- f. Diabetes, thyroid, or any other endocrine disorder? Yes No
- g. Disorder of the skin or lymph glands, arthritis, or any disorder of the muscles, joints or bones? Yes No
- h. Anemia or any other disorder of the blood?. Yes No
- i. A positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system? Yes No

7. Have you:

- a. Experienced any symptom(s) for which you have not yet consulted a health care provider? Yes No
- b. Had any operation(s) in the past 5 years?. Yes No
- c. In the past 5 years been advised to have any operation, treatment, or diagnostic tests that have not yet been performed? Yes No
- d. Had an electrocardiogram, X-ray, or other diagnostic test in the past 5 years (excluding HIV testing)?. Yes No
- e. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? Yes No
- f. In the past 5 years, been confined for observation, care, or treatment in a hospital or other health care facility?. Yes No
- g. In the past 5 years, consulted any health care provider(s) not already identified, for any reason including routine physical examination? Yes No
- h. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer?. Yes No

8. Are you:

- a. Presently taking any medication(s), including non-prescription/over-the-counter medication or supplements? Yes No
- b. Currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? Yes No

TEMPORARY INSURANCE RECEIPT

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
("the Company")



I. PREMIUM RECEIPT *(On the lives of the Proposed Primary Insured and Proposed Other Insured named below)*

Amount Received \$ _____ Date _____ Policy Application Date _____

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS *(For each Proposed Insured named below)*

1. Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
 - a. any type of heart disease, stroke or other vascular disease? Yes No
 - b. any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system? Yes No
2. In the past five years has any Proposed Insured experienced:
 - a. unintentional weight loss? Yes No
 - b. any symptom(s) for which he/she has not yet consulted a Health Care Provider? Yes No
3. Has any Proposed Insured attained age 70? Yes No

III. 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 covering the life or lives of the Proposed Insured(s) 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 issue date, premiums are 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.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.

There is no temporary insurance receipt coverage if:

- Any of the above representations is answered YES or LEFT BLANK.
- If Section 1035 exchange paperwork is received without premium payment.
- 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.)
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name *(please print)* _____ Signed at *(city/state)* _____

 Proposed Owner Signature _____ Date _____

Proposed Insured Name *(please print)* _____ Signed at *(city/state)* _____

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

Proposed Other Insured Name *(please print)* _____ Signed at *(city/state)* _____

 Proposed Other Insured Signature _____ Date _____

Writing Agent Name *(please print)* _____ Agent Phone _____

 Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE CENTER 2ND COPY TO PROPOSED INSURED

CHILDREN'S INSURANCE RIDER APPLICATION

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
 A member of the ING family of companies
 ("the Company")



BASE POLICY PROPOSED INSURED INFORMATION (Parent or Guardian)

1. First Name _____ MI _____ Last Name _____
 2. Birth Date _____ Amount of Coverage _____
 3. Policy Number (if this coverage is to be added to a policy previously issued on the life of the Proposed Insured) _____
 4. Family Address (PO Boxes are not permitted.) _____
 City _____ State _____ ZIP _____

5. **Proposed Insured Children:** Provide the following information regarding the children of the Proposed Insured, including stepchildren and lawfully adopted children.

Full Name	Gender	Birth Date	SSN	Birth State	Height	Weight	Total Life Insurance now Inforce

Provide details to "Yes" answers for questions #6-17 in space provided in question #18.

- 6. a. Has an application on any child for any life, accident or health insurance not been granted as applied for in kind, amount, or rate? Yes No
 b. Has any insurance issued on the life of any child been cancelled or the renewal or reinstatement thereof refused? Yes No
 - 7. Has any child in the past five years made or does any child anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? (If yes, complete Aviation Questionnaire.) Yes No
 - 8. Does any child participate in hang gliding, soaring, sky diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, rodeos, or any other hazardous sport or activity? (If yes, complete appropriate questionnaire.) Yes No
 - 9. Does any child race, test or stunt drive automobiles, motorcycles, motor boats or jet powered vehicles, or use or race snowmobiles, dirt bikes, dune buggies, etc.? (If yes, complete Motor Sports or Avocations and Professional Sports Questionnaires.) Yes No
 - 10. Within the past 5 years, has any child consulted a member of the medical profession or health practitioner ("health care provider") or visited a hospital or other health care facility as a patient? Yes No
 - 11. Does any child plan to consult a health care provider or be seen as a patient at a clinic or hospital within the next 30 days? Yes No
 - 12. Has any child ever received medical advice or treatment for chest pain, shortness of breath, tumor or cancer, brain, heart, lung, liver or kidney disorder, diabetes, stroke, high blood pressure, mental or nervous disorders, or use of alcohol or drugs? Yes No
 - 13. In the past 10 years has any child ever been treated for or been diagnosed by a health care provider as having a positive HIV (Human Immunodeficiency Virus) test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system? Yes No
 - 14. Does any child listed above not reside with the Base Policy Proposed Insured (Parent or Guardian)? Yes No
 - 15. Does any child currently have life insurance inforce or applied for? (If yes, provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.) Yes No
 - 16. Is any Proposed Insured or Owner considering using funds from existing policies or contracts to pay premiums due on the new policy or contract? (If yes, complete state required replacement form and provide details below.) Yes No
 - 17. Is any Proposed Insured or Owner considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating an existing policy or contract? (If yes, complete state required replacement form and provide details below.) Yes No
- Insured _____ Company _____ Amount \$ _____
 Insured _____ Company _____ Amount \$ _____

18. Remarks and details for "YES" answers to questions #6-17.

Qu. #	Child Name	Condition	Diagnosis	Dates/Duration of Condition/Treatment	Physician Name	Physician Address

AUTHORIZATION AND ACKNOWLEDGEMENT

Verification. By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and declare that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. The Company will have no liability under this Rider Application until all requirements are met, a Children's Insurance Rider is delivered to and accepted by me, and the first premium is received by the Company while the proposed insured(s)/child/children are alive. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

Statements of Understanding. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original. I give my permission to the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me and/or the proposed insured child/children for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied.

I acknowledge receipt of the following disclosures and notices: Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. I certify, under penalty of perjury, that the Social Security Number(s)/tax identification number(s) are shown and are correct is shown and is correct and that I am not subject to back-up withholding.

I agree that this application will form part of any Policy with a Children's Insurance Rider that may be issued, or will form part of any Policy already in force for which a Children's Insurance Rider is issued in response to this application; that no Agent or Medical Examiner is authorized to waive the answers to any questions in this application, decide on insurability, change any of the Company's underwriting requirements or make any change to any contract provision. Further, I agree that no such Children's Insurance Rider will take effect unless during the lifetime and continued insurability, as stated in the application of the Proposed Insured and the Children listed: (1) the Agent has delivered a Policy with the Rider attached or has delivered the Rider for attachment to a Policy already in force, to the Owner of the Policy, (2) the Owner has accepted such Policy with Rider attached or such Rider for attachment to a Policy already in force, and (3) the first premium for the Rider and any Policy of which the Rider is a part has been paid.

If an investigative consumer report is prepared, I request to be interviewed. Yes No

Daytime phone number: () .
Contact me between the hours of ____ a.m./p.m. and ____ a.m./p.m.

By signing below I acknowledge and agree that any Rider issued in relation to this Application (the "Rider") shall be subject to the following Governing Law and Jurisdiction provisions:

Governing Law. The Rider shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

Jurisdiction. Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Rider or sale of the Rider ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Rider is delivered. The state and federal courts located in the state in which the Rider is delivered shall have jurisdiction over the parties to the Action or Proceeding.

All completed materials must be sent to the ING Customer Service Center at: 2000 21st Ave. NW, Minot, ND 58703

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

Proposed Owner Signed at (City, State) _____ Date _____

 Base Policy Proposed Insured Signature _____ Date _____
(if age 15 or older)

 Parent/Guardian Signature _____ Date _____
(if other than Base Policy Proposed Insured)

 Proposed Owner Signature² _____ Date _____
(if other than Proposed Insured)

 Agent Signature _____ Agent ID Number _____ Date _____

² The Proposed Owner is the same Owner that is listed on the base policy attached to this Rider.

AMENDMENT TO [APPLICATION]

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401

Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203

ING Customer Service Center, 2000 21st Ave, NW, Minot, ND 58703

A member of the ING family of companies



Policy Number _____

[Proposed] Insured(s) Name _____

[Proposed] Other Insured(s) Name _____

I amend my **[Individual Life Insurance Application]** dated _____ as follows. I understand and agree that this is part of my application and will be considered part of my policy/contract.

[Section/Question of the attached application has been amended to read:]

 **[Proposed]** Insured Signature _____ Date _____

 **[Proposed]** Other Insured Signature _____ Date _____

 Owner Signature _____ Date _____

ADDITIONAL STATEMENT TO APPLICATION

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401

Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203

A member of the ING family of companies

("the Company")

ING Customer Service Center: PO Box 5075, Minot, ND 58702-5075

Phone: 800-626-2286 (toll free) Fax: 877-788-3152 (toll free)



Proposed Insured Name _____

Proposed Other Insured Name _____

Policy Number _____ Original Application Part I Date _____

1. The following changes and additional statements are made to the application for insurance on the life of the above proposed insured.

Insured Name _____ Changes _____

Insured Name _____ Changes _____

2. Excluding any changes and statements specified above, I affirm that since the above date of my application to the Company:

- a. I have not consulted or been prescribed for by a member of the medical profession or a health practitioner;
- b. I have not made an application for insurance to any other company;
- c. There has been no change in my occupation, residence, or family history;
- d. I have suffered no illness or injury;
- e. No company or association has taken any adverse action with reference to my insurability;
- f. To the best of my knowledge and belief, I am now in good health; and
- g. There has been no change in my non-medical or financial information as stated in the application, including the amounts of insurance applied for and in force on my life with all companies.

It is agreed that this amendment is part of the application and of the policy issued, and it will be binding on any person who will have any interest under the policy. This Amendment, and the Policy, will not take effect until signed as required below. It is agreed that no coverage is in effect if any alterations are made to the above statements on this Amendment.

I agree that these changes and statements shall be made a part of my application for insurance as if they had originally been set forth in such application. They shall be subject in all respects to the agreements contained in the application.

➡ Proposed Insured Signature _____ Date _____

➡ Proposed Other Insured Signature _____ Date _____

➡ Agent/Witness Signature _____ Date _____

➡ Owner Signature (if different from proposed insured) _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION ALCOHOL USAGE QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name (please print) _____ Birth Date _____

1. Do you drink alcoholic beverages? Yes No

If "Yes," quantity in ounces:

	Beer	Wine	Liquor
Daily			
Weekly			

2. Did you ever drink substantially more than you do now? Yes No

If "Yes," when? _____ to _____ (month/year)

If "Yes," former consumption in ounces:

	Beer	Wine	Liquor
Daily			
Weekly			

3. Have you ever consulted a physician, received treatment or professional advice, or been hospitalized because of your alcohol use? . . Yes No

If "Yes," list dates, hospitals, treatment centers, and names and addresses of medical professionals. _____

4. Have you ever been convicted of driving while under the influence of alcohol? Yes No

If "Yes," provide dates, charges and resolution. _____

5. Are you currently a member of Alcoholics Anonymous (AA)? Yes No

6. Were you previously a member of AA but currently are not a member? Yes No

If "Yes," please provide the reason(s) that you stopped participating in AA. _____

7. How long have you totally abstained from drinking alcoholic beverages? _____

8. Please add any information that you feel is important concerning your use of alcohol, before and/or after treatment. _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION AVIATION QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
 A member of the ING family of companies
 ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name (please print) _____ Birth Date _____

1. Describe your civilian and/or military flying experience in the chart below.

Type of Flying	Hours Flown as Pilot or Co-Pilot			Hours Flown as Crew Member			Hours Flown as Passenger	
	Last 12 Months	1-2 Years Ago	Estimated Next 12 Months	Last 12 Months	1-2 Years Ago	Estimated Next 12 Months	Last 12 Months	Estimated Next 12 Months
a. Civilian Non-Commercial								
Pleasure								
Personal Business								
Other, including any experimental aircraft (Complete 2 & 3 below)								
b. Civilian Commercial								
Scheduled Airlines and Freight							XX	XX
Non-scheduled Airlines and Freight								
Company-Owned Plane								
Other (Complete 2 & 3 below)								
c. Military (Complete 7 below)								

2. Provide details about any type of flying experience not indicated above. _____

3. Provide details about all types of aircraft flown, including experimental and lighter-than-air aircraft, gliders and helicopters. Also provide the annual hours spent in each type. _____

4. Circle all categories that describe your other flying experience: aerobatics, charter (air taxi, sightseeing), crop dusting, fish and game, forestry (fire fighting), inspection (pipe, power, telephone line), instruction, mapping, photography, racing, spraying, surveying, testing (production line or prototype), and any other. Provide details in # 9.

5. a. Total hours flown as a pilot _____ b. Date of last flight you piloted _____

c. Do you expect to fly in the future? Yes No

d. If future flying plans differ from past flying experience, please explain. _____

6. a. What type of pilot certificate do you hold? Student Private Recreational Commercial ATP Sport

b. Issue Date _____

c. Do you have additional ratings? Instrument Multi Engine Instructor Other _____

d. What class of medical certificate do you hold? _____ e. Date of last renewal _____

f. Was the medical certificate granted subject to a physical waiver? (If "Yes", provide details in #9) Yes No

g. Have you ever been grounded, been penalized for a violation of Federal Aviation Regulations or had your license revoked? (If "Yes," provide details in #9) Yes No

7. a. If you have flown for military purposes, what is/was your branch of service or what military connection do you have? _____

b. If your military experience is/was as a crew member, provide the job title. _____

c. List your duty assignments (FLOGS, MATS, SAC). _____

d. If currently a pilot in the military, what aircraft do you now fly? (Provide complete description of aircraft types, where based, and flight destinations.)

e. Do you anticipate any change in your duties or the type of aircraft you fly? (If "Yes," provide details in #9.) Yes No

8. In lieu of aviation coverage with an extra premium charge, do you want your policy issued with restricted aviation coverage without extra premium? Yes No

9. Additional remarks _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION DRUG USAGE QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name (please print) _____ Birth Date _____

1. Have you ever used or do you now use:
- a. Opiates (e.g. codeine, heroin, methadone)? Yes No
 - b. Barbiturates (e.g. amytal, phenobarbital)? Yes No
 - c. Non-Barbiturate sedatives (e.g. Placidyl®, Doriden®)? Yes No
 - d. Amphetamines (e.g. Benzedrine®, Dexedrine®, Preludin®)? Yes No
 - e. Anticholinergics (e.g. belladonna, bromide, cocaine)? Yes No
 - f. Hallucinogens (e.g. LSD, peyote, psilocybin)? Yes No
 - g. Cannabis (e.g. marijuana, hashish)? Yes No

Provide details of extent, time frame and duration of use and drugs used. _____

2. Have you increased or decreased your pattern of drug use? Yes No

If "Yes," when and why? _____

3. Have you ever consulted a physician, received treatment or professional advice, or been hospitalized because of your drug use? Yes No

If "Yes," list dates, hospitals, treatment centers, and names and addresses of medical professionals. _____

4. Have you ever been arrested and convicted in connection with drug use or possession of drugs? Yes No

If "Yes," explain. _____

5. How long have you totally abstained from use of drugs (other than drugs legally prescribed to you by a physician)? _____

6. Please add any additional information that you feel is important concerning your use of drugs. _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION FOREIGN TRAVEL AND RESIDENCE QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name (please print) _____ Birth Date _____

1. Country of Origin¹ _____ Current Citizenship _____

2. Date of entry into the United States (if applicable) _____

3. Visa type, symbol, number, and expiration date (if applicable) _____

4. Do you live full-time in the USA? Yes No

If "No", list all cities and countries resided in, and the number of weeks/years in each. _____

5. Do you intend to remain permanently in the USA? Yes No

6. Do you plan to travel outside the USA in the next two years? Yes No

If "Yes", provide details for each country to include specific locations, departure dates, duration and purpose of stay. _____

7. List your assets/property both within and outside the USA _____

8. List immediate family members by relationship, age, and citizenship

Within the USA _____

Outside the USA _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

¹ Do not answer if you are a resident of California.

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION MILITARY QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name (please print) _____ Birth Date _____

1. Are you now on active duty with the Armed Forces? Yes No

If "Yes," answer the following:

a. Branch of Service _____

c. Do your duties involve flying in military planes either as a passenger or otherwise? Yes No

b. Rank _____ Yes No

d. Have you ever flown as a pilot or crew member? Yes No

If c. or d. is answered "Yes," complete the Aviation Questionnaire.

e. Have you ever been alerted for or received orders for duty outside the United States? Yes No

If "Yes," explain fully. _____

2. Are you now a member of the National Guard, Air National Guard or any reserve component of the Armed Forces? Yes No

If "Yes," answer the following:

a. Branch of Service _____ b. Rank _____

c. Do your duties involve flying in military planes either as a passenger or otherwise? Yes No

d. Have you ever flown as a pilot or crew member? Yes No

If c. or d. is answered "Yes," complete the Aviation Questionnaire.

e. Have you or your unit been alerted for active service? Yes No

If "Yes," explain fully. _____

3. Additional Remarks _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION MOTOR SPORTS QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name (please print) _____ Birth Date _____

1. Do you participate in motor sport exhibitions or organized competitions? Yes No

If "Yes," check all the events in which you have participated or plan to participate:

- | | | |
|---|--|--|
| <input type="checkbox"/> All terrain vehicles (ATV) | <input type="checkbox"/> Rally | <input type="checkbox"/> Wheelie competitions |
| <input type="checkbox"/> Gyro-stabilized land or water vehicles | <input type="checkbox"/> Hovercraft and hydrofoils | <input type="checkbox"/> Motorcycles |
| <input type="checkbox"/> Championship cars | <input type="checkbox"/> Sports cars | <input type="checkbox"/> Auto-crash |
| <input type="checkbox"/> Demolition or destruction derby | <input type="checkbox"/> Sprint cars | <input type="checkbox"/> Scooters |
| <input type="checkbox"/> Jet car exhibitions | <input type="checkbox"/> Midget cars | <input type="checkbox"/> Snowmobiles |
| <input type="checkbox"/> Kart races | <input type="checkbox"/> Mini cars | <input type="checkbox"/> Dune or sand buggy or cycle |
| <input type="checkbox"/> Economy runs | <input type="checkbox"/> Pike's Peak hill climb | <input type="checkbox"/> Time speed trials |
| <input type="checkbox"/> Figure & demolition derby | <input type="checkbox"/> Auto-ice | <input type="checkbox"/> Off road, desert, trail competition |
| <input type="checkbox"/> Football demolition derby, auto football or soccer | <input type="checkbox"/> Drag racing | <input type="checkbox"/> Others (explain below) |
| <input type="checkbox"/> Formula racing | <input type="checkbox"/> Stock cars | |
| | <input type="checkbox"/> Swamp buggies | |

2. In what specific events do you compete with the vehicle(s) listed above? _____

3. In what class do you compete? (Include make, model, engine size, vehicle class designation) _____

4. Under what sanctioning body do you normally compete? (ex: AMA, NHRA, SCCA, ASAC) _____

5. Do you compete professionally? Yes No

6. How many races or events did you participate in during the past twelve months? _____

7. How many races or events do you anticipate participating in during the next twelve months? _____

8. What is the average length of these events? (In miles, laps, or time, as appropriate) _____

9. What is your average speed? _____ What is your top speed? _____

10. Do you anticipate any changes in your participation in the next twelve months? Yes No

If "Yes," provide details. (different events, new class) _____

11. Additional Remarks _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION SCUBA DIVING QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name *(please print)* _____ Birth Date _____

Diving Experience and Qualifications

- 1. When and where did you learn to dive? _____
- 2. Are you an active member of a diving club? Yes No
- 3. What diving qualifications do you hold? _____
- 4. How many dives per year have you made in each of the last 3 years? _____
- 5. What is the average time you spend under water per dive? _____
- 6. Where do you dive? _____
- 7. What is the maximum depth you dive to? _____
- 8. Do you ever dive unaccompanied? Yes No

Future Diving Plans *(in the next 24 months)*

- 9. How many dives do you plan to make each year? _____
- 10. What depth will you usually dive to? _____
- 11. What type of equipment will you use? _____

Purpose of Dives

- 12. For what purpose do you dive (e.g., photography or marine biology)? _____
- 13. Do you dive commercially or for profit? Yes No
- 14. Do you participate in any of the following dives?
 - Wreck diving (observation, salvage, photography or exploration) Yes No
 - Cave or pothole diving Yes No
 - Treasure diving Yes No
 - Ice diving Yes No
 - Diving at high altitudes (i.e. mountain lakes) Yes No
 - Depth record attempts Yes No

Provide details about the frequency and locations of the dives indicated above. Include any other information that may clarify your responses on this questionnaire.

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION TOBACCO/NICOTINE USE QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
A member of the ING family of companies
ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Proposed Insured Name *(please print)* _____ Birth Date _____

Describe your use of tobacco or nicotine products by completing all of the questions below.

Current User of Tobacco or Nicotine Products

1. Do you currently use:

- a. Cigarettes Yes No *If "Yes," provide the number of packs of cigarettes per day.* _____
- b. Cigars Yes No *If "Yes," provide the number of cigars per day.* _____
- c. Pipe Yes No
- d. Chewing Tobacco Yes No
- e. Nicotine Gum Yes No
- f. Nicotine Patches Yes No
- g. Other Nicotine or Tobacco products Yes No

Former User of Tobacco or Nicotine Products

2. Have you formerly used, but no longer use the following:

- a. Cigarettes Yes No
If "Yes," provide the month and year last used. _____
- b. Cigars Yes No
If "Yes," provide the month and year last used. _____
- c. Pipe Yes No
If "Yes," provide the month and year last used. _____
- d. Chewing Tobacco Yes No
If "Yes," provide the month and year last used. _____
- e. Nicotine Gum Yes No
If "Yes," provide the month and year last used. _____
- f. Nicotine Patches Yes No
If "Yes," provide the month and year last used. _____
- g. Other Nicotine or Tobacco products Yes No
If "Yes," provide the month and year last used. _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION AVOCATIONS AND PROFESSIONAL SPORTS QUESTIONNAIRE

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401

Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203

A member of the ING family of companies

ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



Your future. Made easier.®

Proposed Insured Name (please print) _____ Birth Date _____

1. Check (on the left) all appropriate Avocational and Professional Sports activities in which you participate. Check (on the right) all times in which you did or plan to participate. (If you participate in motorized vehicle sports or avocations, complete the Motor Sports Questionnaire.)

CHECK IF A PARTICIPANT	ACTIVITY	PAST 12 MONTHS AND/OR CURRENTLY	NEXT 12 MONTHS AND/OR FUTURE
<input type="checkbox"/>	Aquascooters	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Balloonist		
<input type="checkbox"/>	<input type="checkbox"/> Amateur	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Professional/Commercial	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Bicycle Riders (indicate in remarks whether sprint, pursuit, or motor pace)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Boataloon	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Bobsled racers (2 and 4 person)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Boxers and prizefighters (professional)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Canoe and kayak	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Tobogganers, sledders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> White water slalom, downriver	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cliff divers		
<input type="checkbox"/>	<input type="checkbox"/> International competitors and professional	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Others (give details in remarks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dune soarers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hang balloonist	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hang gliding	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Horse racers and competitors		
<input type="checkbox"/>	<input type="checkbox"/> Harness racing drivers (pacing & trotting)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Jockeys	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Steeplechase riders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hunters - big game (give details in remarks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Kiters	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Laserteers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Luge racers (1 & 2 person)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Motorboard surfers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Mountain climbers		
<input type="checkbox"/>	<input type="checkbox"/> North American continent		
<input type="checkbox"/>	<input type="checkbox"/> Rock climbers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Trail climbers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Elsewhere		
<input type="checkbox"/>	<input type="checkbox"/> Rock climbers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Trail climbers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Para-gliders, para-kiters, para-sailers, para-scuba	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Para-skiers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Powerboat or motorboat racing, testing, or stunt driving	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Power skiers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Rocketeers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Experimental metal rockets using home-mixed propellants	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Rodeo		
<input type="checkbox"/>	<input type="checkbox"/> Clowns (professional)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Performers		
<input type="checkbox"/>	<input type="checkbox"/> Amateur	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Professional	<input type="checkbox"/>	<input type="checkbox"/>

CHECK IF A PARTICIPANT	ACTIVITY	PAST 12 MONTHS AND/OR CURRENTLY	NEXT 12 MONTHS AND/OR FUTURE
<input type="checkbox"/>	Sand surfers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Sand Yacht Racers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Skiers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Acrobats	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Ski jumpers, downhill racers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Skydivers and sport parachutist	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Amateur	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Professional	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Spelunkers (including members of search and rescue units)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Surfers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> International competitors and professionals	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Others	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Target divers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> International competitors and professionals	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Others	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Water kites	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Water skiers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> International competitors and professionals	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Water ski racing	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Water ski speed records	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Wrestlers (professional)	<input type="checkbox"/>	<input type="checkbox"/>

2. How long have you been participating in this activity or activities? _____

3. How frequently do you participate in this activity or activities? (Include total participation in the past 2 years.) _____

4. Are you a member of an organized club or certified? Yes No

Club name and location or certification type _____

5. Do you participate professionally or in competitive events? Yes No

Provide details of these events _____

6. What type of equipment is used? _____

7. Where do you participate in the activity(ies) (city, state, country)? _____

8. Have you attempted or do you intend to attempt any height, distance, or duration records? Yes No

If yes, give details. _____

9. Have you ever or do you intend to use experimental equipment of either a manufacturer's or your own design? Yes No

If yes, give details. _____

10. Within what parameters of your activity do you participate? Explain. (Use criteria that indicate the level of risk involved, for example, greatest altitude, speed, or depth achieved, is equipment owned or rented, types of events entered, competition class, etc.) _____

11. Remarks _____

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

 Proposed Insured Signature _____ Date _____

SERFF Tracking Number: INGD-126167275 State: Arkansas
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 42558
Company Tracking Number: 153793
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: General and Variable Account Individual Life Insurance Application
Project Name/Number: General and Variable Account Individual Life Insurance Application/153793

Supporting Document Schedules

Item Status:

**Status
Date:**

Satisfied - Item: Flesch Certification

Comments:

See attached.

Attachments:

RS AR L&H Certification Reg 19.pdf

RS Flesch Readability Certification.pdf

Item Status:

**Status
Date:**

Bypassed - Item: Application

Bypass Reason: Not Applicable to this application filing.

Comments:

**ARKANSAS
CERTIFICATION**

Re:

153793 Individual Life Insurance Application
153808 Individual Life Insurance Application Part II - Medical Declarations
153795 Individual Life Insurance Application Part II - Medical Examination
153794 Temporary Insurance Receipt
153796 Children's Insurance Rider Application
153813 Amendment to Application
153849 Additional Statement to Application
153836 Supplement to Individual Life Insurance Application - Alcohol Usage Questionnaire
153837 Supplement to Individual Life Insurance Application - Aviation Questionnaire
153838 Supplement to Individual Life Insurance Application - Drug Usage Questionnaire
153839 Supplement to Individual Life Insurance Application - Foreign Travel or Residence Questionnaire
153840 Supplement to Individual Life Insurance Application - Military Questionnaire
153841 Supplement to Individual Life Insurance Application - Motor Sports Questionnaire
153842 Supplement to Individual Life Insurance Application - Scuba Diving Questionnaire
153843 Supplement to Individual Life Insurance Application - Tobacco/Nicotine Use Questionnaire
153844 Supplement to Individual Life Insurance Application - Avocations and Professional Sports Questionnaire

We hereby certify that this submission meets the provisions of Regulation 19 and all applicable requirements of the Arkansas Insurance Department.

ReliaStar Life Insurance Company

By:



Terry Stumpf, Assistant Secretary

Date: June 1, 2009

**RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota**

FLESCH READABILITY CERTIFICATE

I certify that the forms included in this submission have been printed in not less than ten point type.

The style, arrangement and overall appearance of the forms give no undue prominence to any portion of the text of the forms.

The section titles are captioned in bold face type. The layout and spacing of the forms separate the paragraphs from each other and from the border of the paper.

Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in these forms.

Flesch Scale Reading Ease Score

I have supervised the computation of the Flesch scale reading ease score of these forms, using the complete text of the forms except for headings, indexes and tabular material, and the scores are listed below.

Form Numbers	Flesch Reading Ease Scores
153793	50.5
153808	70.6
153795	50.8
153794	51.9
153796	51.7
153813	59.4
153849	57.2
153836	53.2
153837	50.8
153838	54.1
153839	76.5
153840	73.2
153841	61.3
153842	68.0
153843	87.3
153844	51.6

Signed



Terry Stumpf
Assistant Secretary

Date: June 1, 2009