

SERFF Tracking Number: MNNP-127891398 State: Arkansas
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 50560
Company Tracking Number: EOI - LIFE
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: EOI 2011
Project Name/Number: /

Filing at a Glance

Company: ReliaStar Life Insurance Company

Product Name: EOI 2011

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Filing Type: Form

SERFF Tr Num: MNNP-127891398 State: Arkansas

SERFF Status: Closed-Approved- State Tr Num: 50560
Closed

Co Tr Num: EOI - LIFE

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Kathy Healy, Katie Onnen, Disposition Date: 01/05/2012
Dawn Olson

Date Submitted: 12/23/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 01/05/2012

State Status Changed: 12/29/2011

Deemer Date:

Created By: Katie Onnen

Submitted By: Katie Onnen

Corresponding Filing Tracking Number: MNNP-127891469

Filing Description:

Re: ReliaStar Life Insurance Company

NAIC #0229-67105, FEIN 41-0451140

Evidence of Insurability RL-EOI-2011-MULTI-FR

Evidence of Insurability – Short Form RL-EOI-SHORT-2011-MULTI-FR

Addendum to Evidence of Insurability – Short Form RL-ADDENDUM-2011-MULTI-FR

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We enclose the captioned forms for filing with your Department. If required by your state we are submitting identical filings to both the Life and Health Divisions. Where applicable, the corresponding SERFF Tracking numbers are included immediately above the Filing Description.

These forms are new and have not been approved or disapproved by your department. They are being filed for use with both paper enrollments as well as for electronic online enrollments. Upon approval, the submitted forms will be used with all of the following group products:

Group Term Life Policy LP00GP, approved on 09/01/1998
Group Disability Income Policy HP08GP, approved on 11/05/2002
Group Long Term Disability Income Policy HP13GP, approved on 01/06/2011

The Evidence of Insurability application will be used with our approved Group Life Insurance and Group Disability Income Insurance products when a full medical underwriting review is required, unless the Evidence of Insurability – Short Form described below is used.

The Evidence of Insurability – Short Form is a “simplified issue” application that will be used with Group Life Insurance only, and will be used if a group allows applicants to apply for additional amounts of coverage above the guaranteed issue amount, if any, without submitting to a formal medical underwriting process.

- If questions 1, 2 and 4 are answered “No,” and the answers to question 3 (height and weight) are within acceptable limits, the applicant will be approved for the amount applied for in addition to the guaranteed issue amount, if any.
- If either questions 1 or 2 are answered “Yes,” the applicant will be denied the additional amount applied for but will still be eligible for any guaranteed issue amount of coverage.
- If questions 1, 2 and 3 are answered acceptably but 4 is answered “Yes,” the applicant will be required to provide additional medical information contained in the Addendum to Evidence of Insurability – Short Form.

The Addendum to Evidence of Insurability – Short Form will be used when the answers on an applicant’s Evidence of Insurability – Short Form require additional medical underwriting. The health questions on this Addendum, when combined with those on the Short Form, are identical to the questions contained on the Evidence of Insurability form.

These forms are intended for use in both paper and electronic format. For example: 1) typeset and printed as a multi-sided form; 2) printed from an electronic forms library; and 3) as an electronic form, with information recorded and signed on-line, with the applicant given the option to print, save, or have mailed to them an exact copy of their signed application.

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For any paper forms completed either through a paper enrollment process or printed after being completed electronically, at some point in the future a barcode containing information applicable to each employer group may be added to the top of each form to enable scanning and indexing into our imaging system.

For electronic enrollments, the actual wording of the online statements and questions will not change, but based on the applicant's responses, they may appear in a different order. In addition, if either questions #1 or #2 are answered "Yes" on either the Evidence of Insurability application or the Evidence of Insurability – Short Form, no additional questions will be presented electronically. The applicant would then be taken to the electronic signature section, and would then be declined automatically for any amount above the guaranteed issue amount of coverage without an underwriter's involvement. Logic will be built into the electronic system to allow only the applicable information and questions to appear to the applicant.

Variable text is indicated by brackets, and a Statement of Variability is included.

These forms or substantially similar forms are being filed concurrently in Minnesota, our state of domicile

To the best of my knowledge and belief, this submission complies with the laws, regulations and bulletins of your state. Thank you in advance for your prompt review and consideration of this submission.

Company and Contact

Filing Contact Information

Katie Onnen, Compliance Analyst katie.onnen@us.ing.com
P.O. Box 20 612-372-1048 [Phone]
Route 7787 612-342-3695 [FAX]
Minneapolis, MN 55440-0020

Filing Company Information

ReliaStar Life Insurance Company CoCode: 67105 State of Domicile: Minnesota
P.O. Box 20 Group Code: 229 Company Type:
Minneapolis, MN 55440-0020 Group Name: State ID Number:
(612) 372-5246 ext. [Phone] FEIN Number: 41-0451140

Filing Fees

Fee Required? Yes
Fee Amount: \$150.00

SERFF Tracking Number: MNNP-127891398 State: Arkansas
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Retaliatory? No
Fee Explanation: 3 forms @ \$50 each
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ReliaStar Life Insurance Company	\$150.00	12/23/2011	54802702

SERFF Tracking Number: MNNP-127891398

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Product Name: EOI 2011

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	01/05/2012	01/05/2012
Approved- Closed	Linda Bird	12/29/2011	12/29/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Evidence of Insurability application	Katie Onnen	01/03/2012	01/03/2012
Form	Evidence of Insurability application	Katie Onnen	01/03/2012	01/03/2012
Form	Addendum to Evidence of Insurability application	Katie Onnen	01/03/2012	01/03/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Would you please reopen this filing	Note To Filer	Linda Bird	01/03/2012	01/03/2012
Would you please reopen this filing	Note To Reviewer	Katie Onnen	01/03/2012	01/03/2012
Corresponding SERFF filing MNNP-127880740 - Disability Income	Note To Reviewer	Katie Onnen	12/29/2011	12/29/2011

SERFF Tracking Number: MNNP-127891398 *State:* Arkansas
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Product Name: EOI 2011
Project Name/Number: /

Disposition

Disposition Date: 01/05/2012

Implementation Date:

Status: Approved-Closed

Comment: Company has made correction to the fraud warning language on the original submission.

Rate data does NOT apply to filing.

SERFF Tracking Number: MNNP-127891398 State: Arkansas
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Product Name: EOI 2011
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form (revised)	Evidence of Insurability application		Yes
Form	Evidence of Insurability application	Replaced	Yes
Form (revised)	Evidence of Insurability application		Yes
Form	Evidence of Insurability application	Replaced	Yes
Form (revised)	Addendum to Evidence of Insurability application		Yes
Form	Addendum to Evidence of Insurability application	Replaced	Yes

SERFF Tracking Number: MNNP-127891398

State: Arkansas

Filing Company: ReliaStar Life Insurance Company

State Tracking Number: 50560

Company Tracking Number: EOI - LIFE

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life -
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Product Name: EOI 2011

Project Name/Number: /

Disposition

Disposition Date: 12/29/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: EOI 2011
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form (revised)	Evidence of Insurability application		Yes
Form	Evidence of Insurability application	Replaced	Yes
Form (revised)	Evidence of Insurability application		Yes
Form	Evidence of Insurability application	Replaced	Yes
Form (revised)	Addendum to Evidence of Insurability application		Yes
Form	Addendum to Evidence of Insurability application	Replaced	Yes

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Amendment Letter

Submitted Date: 01/03/2012

Comments:

Ms. Bird,

Thank you for reopening this filing. The fraud warning on the last page has been changed slightly at the request of the examiner reviewing the filing for use with health insurance. No other text changes have been made to these forms, but please note that the form numbers are now state specific to Arkansas.

Thank you for your continued review of this filing.

Katie Onnen

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
RL-EOI-2011-AR	Application/Enrollment Form	Evidence of Insurability application	Revised				53.200	RL-EOI-2011-AR.pdf
RL-EOI-SHORT-AR	Application/Enrollment Form	Evidence of Insurability application	Revised				56.000	RL-EOI-SHORT-2011-AR.pdf
RL-ADDENDUM-2011-AR	Application/Enrollment Form	Addendum to Evidence of Insurability application	Revised				50.000	RL-ADDENDUM-2011-AR.pdf

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Product Name: EOI 2011
Project Name/Number: /

Note To Filer

Created By:

Linda Bird on 01/03/2012 10:06 AM

Last Edited By:

Linda Bird

Submitted On:

01/03/2012 10:06 AM

Subject:

Would you please reopen this filing

Comments:

Filing has been re-opened in order for corrections to be made.

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Product Name: EOI 2011
Project Name/Number: /

Note To Reviewer

Created By:

Katie Onnen on 01/03/2012 09:04 AM

Last Edited By:

Katie Onnen

Submitted On:

01/03/2012 09:04 AM

Subject:

Would you please reopen this filing

Comments:

Ms. Bird,

As we just discussed, I had filed a separate submission under the TOI of H11G (group disability income), and was required to make a slight change to the fraud warning language. I would like to send you these revised forms for your re-approval.

Thanks very much.

Katie Onnen

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Product Name: EOI 2011
Project Name/Number: /

Note To Reviewer

Created By:

Katie Onnen on 12/29/2011 01:03 PM

Last Edited By:

Katie Onnen

Submitted On:

12/29/2011 01:03 PM

Subject:

Corresponding SERFF filing MNNP-127880740 - Disability Income

Comments:

I received the following objection on the above filing:

"This will acknowledge receipt of the captioned filing. Please incorporate "may be subject to fines and confinement in prison" in the fraud warning on all three applications so it will more closely mirror ACA 23-66-503. I can then approve this filing. "

Please note that the forms are being revised now and unless you have any further objections I will add the revised forms to both this and the DI filing when I receive them back.

Thank you,
Katie Onnen

SERFF Tracking Number: MNNP-127891398

State: Arkansas

Filing Company: ReliaStar Life Insurance Company

State Tracking Number: 50560

Company Tracking Number: EOI - LIFE

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: EOI 2011

Project Name/Number: /

Form Schedule

Lead Form Number: RL-EOI-2011-MULTI-FR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	RL-EOI-2011-AR	Application/Evidence of Enrollment Insurability Form application	Revised	Replaced Form #: Previous Filing #:	53.200	RL-EOI-2011-AR.pdf
	RL-EOI-SHORT-AR	Application/Evidence of Enrollment Insurability Form application	Revised	Replaced Form #: Previous Filing #:	56.000	RL-EOI-SHORT-2011-AR.pdf
	RL-ADDENDUM-2011-AR	Application/Addendum to Enrollment Evidence of Insurability application	Revised	Replaced Form #: Previous Filing #:	50.000	RL-ADDENDUM-2011-AR.pdf

EVIDENCE OF INSURABILITY (AR)

ReliaStar Life Insurance Company, Minneapolis, MN
 A member of the ING family of companies
 PO Box 20, Route 7812, Minneapolis, MN 55440
 Phone: 612.342.7262 Fax: 612.342.3913



Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number _____ Account Number _____ Employer Name _____
 Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Address _____ City _____ State _____ ZIP _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Hire Date _____ Salary \$ _____ Occupation _____
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS (Complete this table based only on the coverage you have through this plan.)

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? Yes No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
<input type="checkbox"/> Employee Basic Life	\$	\$	\$	\$
<input type="checkbox"/> Employee Supplemental Life	\$	\$	\$	\$
<input type="checkbox"/> Employee Short Term Disability				
<input type="checkbox"/> Employee Long Term Disability				
<input type="checkbox"/> Spouse Supplemental Life	\$	\$	\$	\$
<input type="checkbox"/> Children Supplemental Life (per child)	\$	\$	\$	\$

C. SPOUSE INFORMATION

Spouse Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Same Primary Health Practitioner as Employee (See information above.)
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

D. CHILD INFORMATION (Availability of Child coverage is dependent on plan rules and may also be dependent on approved employee coverage. If more than 3 children, list information on additional sheet.)

Name (First, MI, Last)	Birth Date	Gender	Relationship
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent Children Health Questions (Answer these questions only if applying for dependent child(ren) coverage.)

1. Within the past 5 years, have any dependent children been treated for or diagnosed with a mental or nervous disorder (excluding ADHD), diabetes, heart disorder, cancer, asthma (requiring hospitalization within the last 2 years), or chemical abuse? Yes No
2. Do any dependent children have cerebral palsy, cystic fibrosis, muscular dystrophy, developmental disorder (including Autism and Down's Syndrome), or complications associated with premature birth? Yes No

For each "Yes" answer, provide name(s) of child(ren) and details. _____

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E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having a positive HIV test or AIDS (Acquired Immunodeficiency Syndrome)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP ---->				3. Employee: Height _____ ft. _____ in. Weight _____ lbs. Spouse: Height _____ ft. _____ in. Weight _____ lbs.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Polycystic kidney disease or kidney failure?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Chest pain, heart trouble or circulatory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Anemia or leukemia?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Sleep apnea, asthma or other respiratory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Stomach disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Brain or seizure disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Mental or nervous disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Arthritis, paralysis or any muscle weakness?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Abnormal urine specimen or urinary tract disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Prostate or other reproductive organ disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

If applying for disability income coverage, please complete this additional question:

<input type="checkbox"/>	<input type="checkbox"/>	- N/A -	10. In the past 5 years have you experienced symptoms of or been treated for arthritis, fibromyalgia, back or neck disorder, spinal disorder, joint or bone disorder, muscle disorder, carpal tunnel syndrome or chronic pain?
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For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Employee Name _____ SSN (Last 4 digits only) _____

F. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations—42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to fines and confinement in prison, and denial of insurance benefits.

 Employee Signature _____ Date _____

 Spouse Signature _____ Date _____

Submit your EOI form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: [1-612-342-3913]

Or

Mail to: [ReliaStar Life Insurance Company, PO Box 20, Route 7812, Minneapolis, MN 55440]

[000000000]

EVIDENCE OF INSURABILITY - SHORT FORM (AR)

ReliaStar Life Insurance Company, Minneapolis, MN
 A member of the ING family of companies
 PO Box 20, Route 7812, Minneapolis, MN 55440
 Phone: 612.342.7262 Fax: 612.342.3913



Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number _____ Account Number _____ Employer Name _____
 Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Address _____ City _____ State _____ ZIP _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Hire Date _____ Salary \$ _____ Occupation _____
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS (Complete this table based only on the coverage you have through this plan.)

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? Yes No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
<input type="checkbox"/> Employee Basic Life	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Employee Supplemental Life	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Spouse Supplemental Life	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Children Supplemental Life (per child)	\$ _____	\$ _____	\$ _____	\$ _____

C. SPOUSE INFORMATION

Spouse Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Same Primary Health Practitioner as Employee (See information above.)
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

D. CHILD INFORMATION (Availability of Child coverage is dependent on plan rules and may also be dependent on approved employee coverage. If more than 3 children, list information on additional sheet.)

Name (First, MI, Last)	Birth Date	Gender	Relationship
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent Children Health Questions (Answer these questions only if applying for dependent child(ren) coverage.)

1. Within the past 5 years, have any dependent children been treated for or diagnosed with a mental or nervous disorder (excluding ADHD), diabetes, heart disorder, cancer, asthma (requiring hospitalization within the last 2 years), or chemical abuse? Yes No
2. Do any dependent children have cerebral palsy, cystic fibrosis, muscular dystrophy, developmental disorder (including Autism and Down's Syndrome), or complications associated with premature birth? Yes No

For each "Yes" answer, provide name(s) of child(ren) and details. _____

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E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having a positive HIV test or AIDS (Acquired Immunodeficiency Syndrome)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP ---->				3. Employee: Height _____ ft. _____ in. Weight _____ lbs. Spouse: Height _____ ft. _____ in. Weight _____ lbs.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Polycystic kidney disease or kidney failure?

F. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations—42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to fines and confinement in prison, and denial of insurance benefits.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Submit your EOI Short Form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: 1-612-342-3913

Or

Mail to: ReliaStar Life Insurance Company, PO Box 20, Route 7812, Minneapolis, MN 55440

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ADDENDUM TO EVIDENCE OF INSURABILITY - SHORT FORM (AR)

ReliaStar Life Insurance Company, Minneapolis, MN
 A member of the ING family of companies
 PO Box 20, Route 7812, Minneapolis, MN 55440
 Phone: 612.342.7262 Fax: 612.342.3913



Employee Name (First, MI, Last) _____ SSN _____

A. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Chest pain, heart trouble or circulatory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Anemia or leukemia?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Sleep apnea, asthma or other respiratory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Stomach disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Brain or seizure disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Mental or nervous disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Arthritis, paralysis or any muscle weakness?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Abnormal urine specimen or urinary tract disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Prostate or other reproductive organ disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

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

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Employee Name _____ SSN (Last 4 digits only) _____

B. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations-42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I understand that the MIB authorization on this form also applies to the health questions on the Evidence of Insurability - Short Form.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to fines and confinement in prison, and denial of insurance benefits.

 Employee Signature _____ Date _____

 Spouse Signature _____ Date _____

Submit this Addendum directly to the insurer for fast and confidential handling via one of the methods below:

Fax to:

Or

Mail to:

SERFF Tracking Number: MNNP-127891398

State: Arkansas

Filing Company: ReliaStar Life Insurance Company

State Tracking Number: 50560

Company Tracking Number: EOI - LIFE

TOI: L04G Group Life - Term

Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: EOI 2011

Project Name/Number: /

Supporting Document Schedules

Item Status:

**Status
Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR_Readability Certification.pdf

Item Status:

**Status
Date:**

Satisfied - Item: Application

Comments:

Please see Form Schedule

Item Status:

**Status
Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability.pdf

READABILITY CERTIFICATION

Arkansas Statutes, Title 23, Chapter 80, Subchapter 2
Life and Disability Insurance Policy Language Simplification Act

ReliaStar Life Insurance Company hereby certifies that (see below), have achieved a Flesch Reading Ease Score of (see below) and comply with the requirements of the Life and Disability Insurance Policy Language Simplification Act.

RL-EOI-2011-MULTI-FR	53.2*
RL-EOI-SHORT-2011-MULTI-FR	56.0*
RL-ADDENDUM-2011-MULTI-FR	50.0*

*After the removal of initial form heading and medical terminology



S. Saver-Patterson
Assistant Secretary

12/13/2011

Date

RELIASTAR LIFE INSURANCE COMPANY

Statement of Variability

Variable information is denoted by brackets

RL-EOI-2011, including either “-MULTI-FR,” “-MULTI-NFR,” or “-(state code)”

BRACKETED MATERIAL	EXPLANATION
Section letters C through F	The text after these letters may be automatically shifted up to preserve the correct sequence in the event one or more sections are revised, as described below.
A member of the ING family of companies. P.O. Box 20, Route 7812, Minneapolis, MN 55440 Phone: 612.342.7262 Fax: 612.342.3913	This information may change in the future. If any of these do change the new information will be inserted in this field.
ING name and logo	The ING name and logo could change in the future. If it does, the new name and logo would be inserted in this field.
Option 1, 2, 3 and 4	These fields will be customized for each group. If all four fields are used the labels would normally be: Location, Class, Division, and Account. To accommodate case specific requests, one or more field labels could also be changed, for example, to include “Employee ID #” or “Other”. If one or more fields are not needed they could be removed.
Section A. EMPLOYEE INFORMATION	All information completed by the applicant is variable to accommodate multiple plan designs in the event there is a change in instruction or in the information needed from the applicant.
Section B. INSURANCE DETAILS	
Are you completing this form due to...	One or more reasons for a change in family status could be added or removed, and the entire line could be either moved or deleted.
Coverage Type	Coverages may be removed if not included with the employer’s plan. The labels could be changed to match the employer’s terminology (i.e., “Voluntary” instead of “Supplemental,” “Associate” instead of “Employee,” etc.).
Column Headings and \$	One or more could be removed based on the employer’s plan.
Section C. SPOUSE INFORMATION	
	The entire section could be removed if spouse coverage not included or not subject to EOI.
	All information completed by the spouse is variable to accommodate multiple plan designs, or if there is a change in instruction or in the information needed by the spouse.
0000000000 on every page	This field will include a unique numerical value to correspond to the displayed last 4 digits of the applicant’s SSN.

RELIASTAR LIFE INSURANCE COMPANY

Statement of Variability

Variable information is denoted by brackets

RL-EOI-2011 including either “-MULTI-FR,” “-MULTI-NFR,” or “-(state code)” (cont’d)

<p>Section D. CHILD INFORMATION</p> <p>(Availability of Child coverage...)</p> <p>Lines for Child information</p> <p>Lines for information if “yes” answers</p>	<p>The entire section could be removed if child coverage not included.</p> <p>Sentence could be expanded to include additional information regarding an employer’s plan rules.</p> <p>Additional lines could be added to allow space to add more children.</p> <p>Additional lines could be added to provide more space. However, no changes would be made to the health questions without refiling.</p>
<p>Section E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS</p> <p>All references to and questions about spouse</p> <p>Employee</p> <p>Questions 3-9</p> <p>Question 10</p>	<p>Could be removed if spouses are not covered under the plan or if spouses are not subject to evidence of insurability.</p> <p>Could be removed if all references to spouse are removed.</p> <p>For electronic enrollments these questions would not be presented if the applicant answers “yes” to either question 1 or 2. In that case they would be declined for any amount above the guaranteed issue amount, if any. However, you have our assurance that even though these questions are marked as variable, no changes to the questions themselves would be made without refiling.</p> <p>Question 10 could be removed if Disability Income coverage not included</p>
<p>Section F. AUTHORIZATION AND ACKNOWLEDGMENT</p> <p>I authorize ReliaStar Life, or its reinsurers...</p> <p>latest</p>	<p>This text may be changed based on the requirements of the MIB General Rules, when finalized. In addition, for electronic enrollments the sentence would be removed in its entirety if the applicant answers “yes” to either question 1 or 2 as described above.</p> <p>Will be removed if the spouse signature line is removed.</p>
<p>Spouse signature and date line</p>	<p>Will be removed if spouse information is removed from the entire form.</p>
<p>Fax number and return address information</p>	<p>This information may change in the future. If any of these do change the new information will be inserted in this field.</p>
<p>0000000000 on every page</p>	<p>This field will include a unique numerical value to correspond to the displayed last 4 digits of the applicant’s SSN.</p>

RELIASTAR LIFE INSURANCE COMPANY

Statement of Variability

Variable information is denoted by brackets

RL-EOI-SHORT-2011 including either “-MULTI-FR,” “-MULTI-NFR,” or “-(state code)”

BRACKETED MATERIAL	EXPLANATION
Section letters C through F	The text after these letters may be automatically shifted up to preserve the correct sequence in the event one or more sections are revised, as described below.
A member of the ING family of companies. P.O. Box 20, Route 7812, Minneapolis, MN 55440 Phone: 612.342.7262 Fax: 612.342.3913	This information may change in the future. If any of these do change the new information will be inserted in this field.
ING name and logo	The ING name and logo could change in the future. If it does, the new name and logo would be inserted in this field.
Option 1, 2, 3 and 4	These fields will be customized for each group. If all four fields are used the labels would normally be: Location, Class, Division, and Account. To accommodate case specific requests, one or more field labels could also be changed, for example, to include “Employee ID #” or “Other”. If one or more fields are not needed they could be removed.
Section A. EMPLOYEE INFORMATION	All information completed by the applicant is variable to accommodate multiple plan designs in the event there is a change in instruction or in the information needed from the applicant.
Section B. INSURANCE DETAILS	
Are you completing this form due to...	One or more reasons for a change in family status could be added or removed, and the entire line could be either moved or deleted.
Coverage Type	Coverages may be removed if not included with the employer’s plan. The labels could be changed to match the employer’s terminology (i.e., “Voluntary” instead of “Supplemental,” “Associate” instead of “Employee,” etc.).
Column Headings and \$	One or more could be removed based on the employer’s plan.
Section C. SPOUSE INFORMATION	The entire section could be removed if spouse coverage not included or not subject to EOI. All information completed by the spouse is variable to accommodate multiple plan designs, or if there is a change in instruction or in the information needed by the spouse.

RELIASTAR LIFE INSURANCE COMPANY

Statement of Variability

Variable information is denoted by brackets

RL-EOI-SHORT-2011 including either “-MULTI-FR,” “-MULTI-NFR,” or “-(state code)” (cont’d)

<p>Section D. CHILD INFORMATION</p> <p>(Availability of Child coverage...)</p> <p>Lines for Child information</p> <p>Lines for information if “yes” answers</p>	<p>The entire section could be removed if child coverage not included.</p> <p>Sentence could be expanded to include additional information regarding an employer’s plan rules.</p> <p>Additional lines could be added to allow space to add more children.</p> <p>Additional lines could be added to provide more space. However, no changes would be made to the health questions without refiling.</p>
<p>Section E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS</p> <p>All references to and questions about spouse</p> <p>Employee</p> <p>Questions 3 and 4</p>	<p>Could be removed if spouses are not covered under the plan or if spouses are not subject to evidence of insurability.</p> <p>Could be removed if all references to spouse are removed.</p> <p>For electronic enrollments these questions would not be presented if the applicant answers “yes” to either question 1 or 2. In that case they would be declined for any amount above the guaranteed issue amount, if any. However, you have our assurance that even though these questions are marked as variable, no changes to the questions themselves would be made without refiling.</p>
<p>Section F. AUTHORIZATION AND ACKNOWLEDGMENT</p> <p>latest</p>	<p>Will be removed if the spouse signature line is removed.</p>
<p>Spouse signature and Date line</p>	<p>Will be removed if spouse information is removed from the entire form.</p>
<p>Fax number and return address information</p>	<p>This information may change in the future. If any of these do change the new information will be inserted in this field.</p>
<p>000000000 on every page</p>	<p>This field will include a unique numerical value to correspond to the displayed last 4 digits of the applicant’s SSN.</p>

RELIASTAR LIFE INSURANCE COMPANY

Statement of Variability

Variable information is denoted by brackets

RL-ADDENDUM-EOI-SHORT-2011 including either “-MULTI-FR,” “-MULTI-NFR,” or “-(state code)”

BRACKETED MATERIAL	EXPLANATION
<p>A member of the ING family of companies. P.O. Box 20, Route 7812, Minneapolis, MN 55440 Phone: 612.342.7262 Fax: 612.342.3913</p> <p>ING name and logo</p>	<p>This information may change in the future. If any of these do change the new information will be inserted in this field.</p> <p>The ING name and logo could change in the future. If it does, the new name and logo would be inserted in this field.</p>
<p>Section A. EMPLOYEE AND SPOUSE HEALTH QUESTIONS INFORMATION</p> <p>AND SPOUSE</p> <p>Boxes for Spouse answers</p>	<p>May be deleted if Addendum only applies to employees.</p> <p>May be deleted if Addendum only applies to employees.</p>
<p>Section B. AUTHORIZATION AND ACKNOWLEDGMENT</p> <p>I authorize ReliaStar Life, or its reinsurers...</p> <p>latest</p>	<p>This text may be changed based on the final requirements of the MIB General Rules, when finalized.</p> <p>Will be removed if the spouse signature line is removed.</p>
<p>Spouse signature and Date line</p>	<p>Will be removed if spouse information is removed from the entire form.</p>
<p>Fax number and return address information</p>	<p>This information may change in the future. If any of these do change the new information will be inserted in this field.</p>

SERFF Tracking Number: MNNP-127891398 State: Arkansas
 Filing Company: ReliaStar Life Insurance Company State Tracking Number: 50560
 Company Tracking Number: EOI - LIFE
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: EOI 2011
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/21/2011	Form	Evidence of Insurability application	01/03/2012	RL-EOI-2011-MULTI-FR.pdf (Superseded)
12/21/2011	Form	Evidence of Insurability application	01/03/2012	RL-EOI-SHORT-2011- MULTI-FR.pdf (Superseded)
12/21/2011	Form	Addendum to Evidence of Insurability application	01/03/2012	RL-ADDENDUM-2011- MULTI-FR.pdf (Superseded)

EVIDENCE OF INSURABILITY

ReliaStar Life Insurance Company, Minneapolis, MN
 A member of the ING family of companies
 PO Box 20, Route 7812, Minneapolis, MN 55440
 Phone: 612.342.7262 Fax: 612.342.3913



Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number _____ Account Number _____ Employer Name _____
 Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Address _____ City _____ State _____ ZIP _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Hire Date _____ Salary \$ _____ Occupation _____
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS (Complete this table based only on the coverage you have through this plan.)

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? Yes No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
<input type="checkbox"/> Employee Basic Life	\$	\$	\$	\$
<input type="checkbox"/> Employee Supplemental Life	\$	\$	\$	\$
<input type="checkbox"/> Employee Short Term Disability				
<input type="checkbox"/> Employee Long Term Disability				
<input type="checkbox"/> Spouse Supplemental Life	\$	\$	\$	\$
<input type="checkbox"/> Children Supplemental Life (per child)	\$	\$	\$	\$

C. SPOUSE INFORMATION

Spouse Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Same Primary Health Practitioner as Employee (See information above.)
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

D. CHILD INFORMATION (Availability of Child coverage is dependent on plan rules and may also be dependent on approved employee coverage. If more than 3 children, list information on additional sheet.)

Name (First, MI, Last)	Birth Date	Gender	Relationship
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent Children Health Questions (Answer these questions only if applying for dependent child(ren) coverage.)

1. Within the past 5 years, have any dependent children been treated for or diagnosed with a mental or nervous disorder (excluding ADHD), diabetes, heart disorder, cancer, asthma (requiring hospitalization within the last 2 years), or chemical abuse? Yes No
2. Do any dependent children have cerebral palsy, cystic fibrosis, muscular dystrophy, developmental disorder (including Autism and Down's Syndrome), or complications associated with premature birth? Yes No

For each "Yes" answer, provide name(s) of child(ren) and details. _____

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E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having a positive HIV test or AIDS (Acquired Immunodeficiency Syndrome)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP ---->				3. Employee: Height _____ ft. _____ in. Weight _____ lbs. Spouse: Height _____ ft. _____ in. Weight _____ lbs.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Polycystic kidney disease or kidney failure?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Chest pain, heart trouble or circulatory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Anemia or leukemia?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Sleep apnea, asthma or other respiratory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Stomach disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Brain or seizure disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Mental or nervous disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Arthritis, paralysis or any muscle weakness?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Abnormal urine specimen or urinary tract disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Prostate or other reproductive organ disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

If applying for disability income coverage, please complete this additional question:

<input type="checkbox"/>	<input type="checkbox"/>	- N/A -	10. In the past 5 years have you experienced symptoms of or been treated for arthritis, fibromyalgia, back or neck disorder, spinal disorder, joint or bone disorder, muscle disorder, carpal tunnel syndrome or chronic pain?
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For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Employee Name _____ SSN (Last 4 digits only) _____

F. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations—42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

 Employee Signature _____ Date _____

 Spouse Signature _____ Date _____

Submit your EOI form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to:

Or

Mail to:

EVIDENCE OF INSURABILITY - SHORT FORM

ReliaStar Life Insurance Company, Minneapolis, MN
 A member of the ING family of companies
 PO Box 20, Route 7812, Minneapolis, MN 55440
 Phone: 612.342.7262 Fax: 612.342.3913



Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number _____ Account Number _____ Employer Name _____
 Option 1 _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Address _____ City _____ State _____ ZIP _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Hire Date _____ Salary \$ _____ Occupation _____
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS (Complete this table based only on the coverage you have through this plan.)

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? Yes No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
<input type="checkbox"/> Employee Basic Life	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Employee Supplemental Life	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Spouse Supplemental Life	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Children Supplemental Life (per child)	\$ _____	\$ _____	\$ _____	\$ _____

C. SPOUSE INFORMATION

Spouse Name (First, MI, Last) _____ Gender: Male Female
 SSN _____ Personal E-mail Address _____ Birth Date _____
 Home Phone (_____) _____ Cell Phone (_____) _____
 Same Primary Health Practitioner as Employee (See information above.)
 Primary Health Practitioner _____ Practitioner Phone (_____) _____
 Practitioner Address _____ City _____ State _____ ZIP _____

D. CHILD INFORMATION (Availability of Child coverage is dependent on plan rules and may also be dependent on approved employee coverage. If more than 3 children, list information on additional sheet.)

Name (First, MI, Last)	Birth Date	Gender	Relationship
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Dependent Children Health Questions (Answer these questions only if applying for dependent child(ren) coverage.)

1. Within the past 5 years, have any dependent children been treated for or diagnosed with a mental or nervous disorder (excluding ADHD), diabetes, heart disorder, cancer, asthma (requiring hospitalization within the last 2 years), or chemical abuse? Yes No
2. Do any dependent children have cerebral palsy, cystic fibrosis, muscular dystrophy, developmental disorder (including Autism and Down's Syndrome), or complications associated with premature birth? Yes No

For each "Yes" answer, provide name(s) of child(ren) and details. _____

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E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having a positive HIV test or AIDS (Acquired Immunodeficiency Syndrome)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP ---->				3. Employee: Height _____ ft. _____ in. Weight _____ lbs. Spouse: Height _____ ft. _____ in. Weight _____ lbs.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Polycystic kidney disease or kidney failure?

F. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations—42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

 Employee Signature _____ Date _____
 Spouse Signature _____ Date _____

Submit your EOI Short Form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: 1-612-342-3913

Or

Mail to: ReliaStar Life Insurance Company, PO Box 20, Route 7812, Minneapolis, MN 55440

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ADDENDUM TO EVIDENCE OF INSURABILITY - SHORT FORM

ReliaStar Life Insurance Company, Minneapolis, MN
 A member of the ING family of companies
 PO Box 20, Route 7812, Minneapolis, MN 55440
 Phone: 612.342.7262 Fax: 612.342.3913



Employee Name (First, MI, Last) _____ SSN _____

A. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Chest pain, heart trouble or circulatory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Anemia or leukemia?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Sleep apnea, asthma or other respiratory disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Stomach disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Brain or seizure disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Mental or nervous disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Arthritis, paralysis or any muscle weakness?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Abnormal urine specimen or urinary tract disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Prostate or other reproductive organ disorder?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

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

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> EE <input type="checkbox"/> SP				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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B. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations-42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I understand that the MIB authorization on this form also applies to the health questions on the Evidence of Insurability - Short Form.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

I understand and agree that any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

 Employee Signature _____ Date _____

 Spouse Signature _____ Date _____

Submit this Addendum directly to the insurer for fast and confidential handling via one of the methods below:

Fax to:

Or

Mail to:

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the ING family of companies



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

Our Underwriting Procedures

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

Privacy and Information Practices

Collecting Information

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

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

Notice Regarding Consumer Reports

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

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

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

Information Maintenance and Disclosure

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

Access to Information

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

Notice Regarding MIB, Inc.

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