

SERFF Tracking Number: MNNP-127891469 State: Arkansas  
Filing Company: ReliaStar Life Insurance Company State Tracking Number: 50559  
Company Tracking Number: EOI - HEALTH  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: EOI 2011  
Project Name/Number: /

## Filing at a Glance

Company: ReliaStar Life Insurance Company  
Product Name: EOI 2011 SERFF Tr Num: MNNP-127891469 State: Arkansas  
TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved State Tr Num: 50559  
Sub-TOI: H11G.005 Combined Short Term and Long Term Co Tr Num: EOI - HEALTH State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Donna Lambert  
Authors: Kathy Healy, Katie Onnen, Dawn Olson Disposition Date: 01/03/2012  
Date Submitted: 12/23/2011 Disposition Status: Approved  
Implementation Date Requested: On Approval Implementation Date: 02/03/2012  
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: 01/03/2012  
State Status Changed: 01/03/2012 Deemer Date:  
Created By: Katie Onnen Submitted By: Katie Onnen  
Corresponding Filing Tracking Number: MNNP-127891398  
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

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

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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.

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.

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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  
 Retaliatory? No  
 Fee Explanation: 3 forms @ \$50 each  
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
ReliaStar Life Insurance Company	\$150.00	12/23/2011	54802966

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/03/2012	01/03/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	12/27/2011	12/27/2011	Katie Onnen	12/30/2011	12/30/2011

SERFF Tracking Number: MNNP-127891469 State: Arkansas  
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## Disposition

Disposition Date: 01/03/2012

Implementation Date: 02/03/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/27/2011
Submitted Date	12/27/2011
Respond By Date	01/27/2012

Dear Katie Onnen,

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.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,  
Donna Lambert

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 12/30/2011  
 Submitted Date 12/30/2011

Dear Donna Lambert,

### Comments:

### Response 1

Comments: We have revised the fraud statement on all forms. Please note that the form numbers have changed to RL-EOI-2011-AR, RL-EOI-SHORT-2011-AR, and RL-ADDENDUM-2011-AR. Thank you.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Evidence of Insurability application	RL-EOI-2011-AR		Application/Enrollment Form	Revised		53.200	RL-EOI-2011-AR.pdf
<b>Previous Version</b>							
Evidence of Insurability application	RL-EOI-2011-MULTI-FR		Application/Enrollment Form	Initial		53.200	RL-EOI-2011-MULTI-FR.pdf
Evidence of Insurability application	RL-EOI-SHORT-2011-AR		Application/Enrollment Form	Revised		56.000	RL-EOI-SHORT-2011-AR.pdf
<b>Previous Version</b>							
Evidence of Insurability application	RL-EOI-SHORT-2011-AR		Application/Enrollment Form	Initial		56.000	RL-EOI-SHORT-2011-AR.pdf

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application	SHORT- 2011- MULTI-FR	Form			SHORT- 2011- MULTI- FR.pdf
Addendum to Evidence of Insurability application	RL- ADDEND UM-2011- AR	Application/Enrollment Form	Revised	50.000	RL- ADDEND UM-2011- AR.pdf
<b>Previous Version</b>					
Addendum to Evidence of Insurability application	RL- ADDEND UM-2011- MULTI-FR	Application/Enrollment Form	Initial	50.000	RL- ADDEND UM-2011- MULTI- FR.pdf

No Rate/Rule Schedule items changed.

Sincerely,  
 Dawn Olson, Kathy Healy, Katie Onnen

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## Form Schedule

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

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/03/2012	RL-EOI-2011-AR	Application/ Enrollment Form	Evidence of Insurability application	Revised	Replaced Form #: Previous Filing #:	53.200	RL-EOI-2011-AR.pdf
Approved 01/03/2012	RL-EOI-SHORT-2011-AR	Application/ Enrollment Form	Evidence of Insurability application	Revised	Replaced Form #: Previous Filing #:	56.000	RL-EOI-SHORT-2011-AR.pdf
Approved 01/03/2012	RL-ADDENDUM-2011-AR	Application/ Enrollment Form	Addendum to 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?
<b>Complete for EE and SP</b> ---->				3. <b>Employee:</b> Height _____ ft. _____ in. Weight _____ lbs. <b>Spouse:</b> 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?
<b>Complete for EE and SP</b> ---->				3. <b>Employee:</b> Height _____ ft. _____ in. Weight _____ lbs. <b>Spouse:</b> 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-127891469 State: Arkansas  
 Filing Company: ReliaStar Life Insurance Company State Tracking Number: 50559  
 Company Tracking Number: EOI - HEALTH  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
 Product Name: EOI 2011  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR_Readability Certification.pdf	Approved	01/03/2012

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> Please see Form Schedule	Approved	01/03/2012

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability <b>Comments:</b> <b>Attachment:</b> Statement of Variability.pdf	Approved	01/03/2012

## 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



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S. Saver-Patterson  
Assistant Secretary

12/13/2011

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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.
<b>Section A. EMPLOYEE INFORMATION</b>	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.
<b>Section B. INSURANCE DETAILS</b>	
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.
<b>Section C. SPOUSE INFORMATION</b>	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><b>Section D. CHILD INFORMATION</b></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, <b>no</b> changes would be made to the health questions without refiling.</p>
<p><b>Section E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS</b></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, <b>no</b> 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><b>Section F. AUTHORIZATION AND ACKNOWLEDGMENT</b></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  ING name and logo	This information may change in the future. If any of these do change the new information will be inserted in this field.  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.
<b>Section A. EMPLOYEE INFORMATION</b>	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.
<b>Section B. INSURANCE DETAILS</b>  Are you completing this form due to...  Coverage Type  Column Headings and \$	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.  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.).  One or more could be removed based on the employer’s plan.
<b>Section C. SPOUSE INFORMATION</b>	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><b>Section D. CHILD INFORMATION</b></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, <b>no</b> changes would be made to the health questions without refiling.</p>
<p><b>Section E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS</b></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, <b>no</b> changes to the questions themselves would be made without refiling.</p>
<p><b>Section F. AUTHORIZATION AND ACKNOWLEDGMENT</b></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)”

<b>BRACKETED MATERIAL</b>	<b>EXPLANATION</b>
<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><b>Section A. EMPLOYEE AND SPOUSE HEALTH QUESTIONS INFORMATION</b></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><b>Section B. AUTHORIZATION AND ACKNOWLEDGMENT</b></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>