

**State:** Arkansas **Filing Company:** ReliaStar Life Insurance Company of New York  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** UNI2 App MIB  
**Project Name/Number:** MIB/

## Filing at a Glance

Company: ReliaStar Life Insurance Company of New York  
Product Name: UNI2 App MIB  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 10/01/2012  
SERFF Tr Num: MNNP-128703340  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num:  
  
Implementation: On Approval  
Date Requested:  
Author(s): C.T. Brasch, Emily Pernu  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 10/05/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

State: Arkansas  
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
 Product Name: UNI2 App MIB  
 Project Name/Number: MIB/

Filing Company: ReliaStar Life Insurance Company of New York

**General Information**

Project Name: MIB  
 Project Number:  
 Requested Filing Mode: Review & Approval  
 Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:

Status of Filing in Domicile: Not Filed  
 Date Approved in Domicile:  
 Domicile Status Comments:  
 Market Type: Individual  
 Individual Market Type:  
 Filing Status Changed: 10/05/2012  
 State Status Changed: 10/05/2012  
 Created By: Emily Pernu  
 Corresponding Filing Tracking Number:

Deemer Date:  
 Submitted By: C.T. Brasch

Filing Description:

Submission is due to MIB requirement, please see the cover letter under Supporting Documents for further information.

**Company and Contact**

**Filing Contact Information**

CT Brasch, Compliance Analyst                      cynthia.brasch@us.ing.com  
 P.O. Box 20    612-372-1132 [Phone]  
 Route 7799    612-342-3695 [FAX]  
 Minneapolis, MN 55440-0020

**Filing Company Information**

ReliaStar Life Insurance Company                      CoCode: 61360    State of Domicile: New York  
 of New York    Group Code: 229    Company Type:  
 P.O. Box 20    Group Name:    State ID Number:  
 Minneapolis, MN 55440-0020                              FEIN Number: 53-0242530  
 (612) 372-5246 ext. [Phone]

**Filing Fees**

Fee Required?    Yes  
 Fee Amount:    \$50.00  
 Retaliatory?    No  
 Fee Explanation:  
 Per Company:    No

Company	Amount	Date Processed	Transaction #
ReliaStar Life Insurance Company of New York	\$50.00	10/01/2012	63273583

SERFF Tracking #:

MNNP-128703340

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

ReliaStar Life Insurance Company of New York

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

UNI2 App MIB

Project Name/Number:

MIB/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/05/2012	10/05/2012

SERFF Tracking #:

MNNP-128703340

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

ReliaStar Life Insurance Company of New York

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

UNI2 App MIB

Project Name/Number:

MIB/

## Disposition

Disposition Date: 10/05/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Cover letter		Yes
Form	UNI2 Application		Yes

SERFF Tracking #:

MNNP-128703340

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

ReliaStar Life Insurance Company of New York

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

UNI2 App MIB

Project Name/Number:

MIB/

## Form Schedule

Lead Form Number: UNI2-RL-1000-MIB

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		UNI2-RL-1000-MULTI-MIB	AEF	UNI2 Application	Initial:	50.300	147108_StateFiling.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

# Life Insurance Application



Product Name \_\_\_\_\_

- ReliaStar Life Insurance Company  
Home Office: Minneapolis, Minnesota 55440
- ReliaStar Life Insurance Company of New York  
Home Office: Woodbury, NY 11797

Type of Enrollment / Change: (check all that apply)

New Application  Increase  Reinstatement  Other \_\_\_\_\_

Administrative Office:  
PO Box 122, Minneapolis, Minnesota 55440-0122

Home Office Use Only - Policy Number(s) and Activation Date(s):

Employee	Spouse	Dependent #1	Dependent #2	Dependent #3

## Section A. Employer and Billing Information

1. Employer: \_\_\_\_\_
2. Group Benefit Plan # \_\_\_\_\_ 3. Pay Mode: \_\_\_\_\_
4. Employee ID #: \_\_\_\_\_ 5. Dept. #: \_\_\_\_\_ 6. Loc. #: \_\_\_\_\_

## Section B. Employee/Owner Information

1. Employee Name: \_\_\_\_\_
2. Address: \_\_\_\_\_  
City, State, ZIP: \_\_\_\_\_
3. Phone #: (\_\_\_\_\_) \_\_\_\_\_ 4. Date of Hire: \_\_\_\_\_ 5. Annual Salary: \$ \_\_\_\_\_
6. Are you actively at work?  Yes  No 7. Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## Section C. Proposed Insured Information

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
	<i>(Complete only if applying for an individual dependent policy.)</i>				
Name					
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate					
Age as of Proposed Effective Date					

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Has the proposed insured used tobacco in any form in the last 24 months? (Respond if 18 years of age or older.)	<input type="checkbox"/> Yes <input type="checkbox"/> No				

**Section D. Proposed Insured Questions**

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
1. Has the proposed Insured ever been diagnosed and/or treated by a member of the medical profession for positive HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome)?	<i>Do not answer for Guaranteed Issue coverage.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2. In the last 90 days, has proposed insured sought or received care or treatment (including taking any daily or ongoing prescribed medication), on an inpatient or outpatient basis, in any hospital, doctor's office or medical care facility for any condition (excluding pregnancy, birth control, colds/flu, allergies, high blood pressure, elevated cholesterol, heartburn/reflux, back trouble, chiropractic care, wellness exams, or diagnostic testing with normal results)? <b>If YES, complete Section F.</b>	<i>Do not answer for Guaranteed Issue coverage.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**Section E. Coverage Information**

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Death Benefit Option (Check one only if Universal Life)	<input type="checkbox"/> Option A <input type="checkbox"/> Option B				
Face Amount	\$	\$	\$	\$	\$
Base <input type="checkbox"/> Weekly <input type="checkbox"/> Premium	\$	\$	\$	\$	\$
Excess <input type="checkbox"/> Weekly <input type="checkbox"/> Premium (Applies to Universal Life only)	\$	\$	\$	\$	\$

**Riders\*/Options**

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Waiver	<input type="checkbox"/> Yes				
CTR Number of Units (Complete Section H)					
ADB Face Amount	\$	\$			
FAIR \$ <input type="checkbox"/> per Week <input type="checkbox"/>	<input type="checkbox"/> \$1.00 <input type="checkbox"/> \$2.00	<input type="checkbox"/> \$1.00			
ABR or LTC or ADBR (Choose Only One)	<input type="checkbox"/> ABR <input type="checkbox"/> LTC <input type="checkbox"/> ADBR	<input type="checkbox"/> ABR <input type="checkbox"/> LTC <input type="checkbox"/> ADBR	<input type="checkbox"/> ABR	<input type="checkbox"/> ABR	<input type="checkbox"/> ABR
Level Term to Age 65 (% and Face Amount)	_____ % \$	_____ % \$			
Other:					
Other:					

<b>Total <input type="checkbox"/> Weekly <input type="checkbox"/> Premium</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
---	-----------	-----------	-----------	-----------	-----------

\*Whole Life Riders: Accelerated Benefit Rider (ABR); Accidental Death Benefit Rider (ADB); Accelerated Death Benefit Rider (ADBR); Children's Term Insurance Rider (CTR); Long Term Care Rider (LTC); Level Term to Age 65 Rider (T65); Waiver of Premium Rider (Waiver).

\*Universal Life Riders: Accelerated Benefit Rider (ABR); Accidental Death Benefit Rider (ADB); Children's Term Insurance Rider (CTR); Face Amount Increase Rider (FAIR); Waiver of Monthly Deduction Rider (Waiver).

**Section F. Supplemental Questions** (Do not complete this Section if applying for Guaranteed Issue coverage.)

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
<b>1. Height</b>  Weight <b>Producer:</b> Does the height and weight exceed the maximum shown on the chart provided?	_____ ft. _____ in. _____ lbs.  <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ ft. _____ in. _____ lbs.  <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ ft. _____ in. _____ lbs.  <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ ft. _____ in. _____ lbs.  <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ ft. _____ in. _____ lbs.  <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2.</b> Has the proposed Insured been diagnosed with or been treated for: any cardiovascular disease or disorder (excluding high blood pressure and functional/innocent heart murmur), stroke, insulin or non-insulin dependent diabetes (excluding gestational diabetes during pregnancy only), cancer (excluding basal cell carcinoma of the skin and/or squamous cell carcinoma of skin) or benign brain tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>3.</b> Has the proposed Insured ever been diagnosed or treated for disorder of the brain (excluding headaches and epilepsy), central nervous system disorder, paralysis, dementia, manic and/or major depression, psychosis or suicide attempt?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>4.</b> Has the proposed Insured ever been diagnosed or treated for chronic lung disease (excluding asthma), sleep apnea, organ transplant, rheumatoid arthritis, chronic blood disorder, or connective tissue disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>5.</b> Has the proposed Insured ever been diagnosed or treated for kidney disease or renal failure, pancreatic disease, liver disease (excluding Hepatitis A), Crohn's disease, or ulcerative colitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>6.</b> Has the proposed Insured sought help or received counseling or treatment for alcohol or drug abuse and not remained substance free for 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>7.</b> In the last 2 years, has the proposed Insured been put on probation or convicted of a felony, Driving Under the Influence (DUI), Driving While Impaired (DWI), or had motor vehicle license revoked or suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>8.</b> In the last 12 months, has the proposed Insured had a recurrent disability, been disabled, or is disabled now?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

If you answered "Yes" to any of the above questions, give details below. Attach an additional sheet of paper if necessary.

Question #	Proposed Insured's Name	Name, address and phone number of Physician/Health Practitioner	Condition/Illness/Injury	Date of Treatment	Remaining Effects

**Section G. Additional Health Question, Authorization and Acknowledgement for Medical Underwriting**  
 (Complete this Section if applying for an amount requiring Medical Underwriting.)

In the past 5 years, has the proposed Insured consulted a health practitioner or other member of the medical profession, received surgical or medical care or taken prescribed medication for any condition (including current treatment), not already indicated on this application? (If you answer Yes, give details below. Attach an additional sheet of paper if necessary.)	<b>Employee</b>	<b>Spouse</b>	<b>Dependent Child #1</b>	<b>Dependent Child #2</b>	<b>Dependent Child #3</b>
	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Proposed Insured's Name	Name, address and phone number of Physician/Health Practitioner	Condition/Illness/Injury	Date of Treatment	Remaining Effects

The responses in this application are complete and true to the best of my knowledge and belief.

I understand that if the policy cannot be issued as applied for, any excess premiums collected will be refunded to the owner. **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 or ReliaStar Life Insurance Company of New York (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, my spouse, or any of my children who are to be insured; and (b) any non-medical information as it applies to me, my spouse, or any of my children who are to be insured. **I give my permission** to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. **I give my permission** to ReliaStar Life to get consumer or investigative consumer reports about these same persons. **I give my permission** to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to get 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 that new use of the information or why another party needs it. **I know** that I have a right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for two years from the date shown below. **I acknowledge** that I have been given ReliaStar Life's Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.

Signed at (City & State):	On (Month, Day, Year):
Signature of Proposed Owner (Employee):	Signature of Proposed Insured Spouse:
Signature of Parent or Guardian:	Signature(s) of Proposed Insured Children Age 18 and Older:

**This signature is for underwriting authorization only. Please continue completing the application and sign on page 6.**

**Section H. Proposed Children's Term Insurance Rider (CTR) Information** (Complete this Section if CTR is elected.)

List all unmarried dependent children who have not attained age 25 on whom Children's Term Insurance is desired. The beneficiary of children's coverage is, in all cases, the Proposed Insured who has the CTR on his/her policy.

Child's First, Middle, Last Name	Birth Date	Relationship	Gender M/F	Is the proposed Insured child hospitalized on the date of this application?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section I. Replacement Information**

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
<b>1.</b> Do you have any existing policies or contracts? (If Yes, complete state Notice Regarding Replacement, if required.) Current Carrier:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>2.</b> Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If Yes, complete state-required replacement form and provide details.)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>3.</b> Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? (If Yes, complete state-required replacement form and provide details.)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>4. Producer:</b> To the best of your knowledge, does this insurance replace any existing insurance or annuities?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

**Section J. Beneficiary Information** (If no beneficiary is designated, the proceeds will be paid to the owner, if living, otherwise to the owner's estate.)

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Beneficiary #1 Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				
Percentage	%	%	%	%	%
Relationship					
Beneficiary #2 Name	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent				
Percentage	%	%	%	%	%
Relationship					
Additional Beneficiary Information					

**SECTION K: Acknowledgement and Certification / Agreement and Signature**

**PROPOSED OWNER'S STATEMENT:** All statements and answers are complete and true to the best of my knowledge and belief. It is agreed that all such statements and answers shall be made a part of any insurance policy/rider(s) issued.

**FRAUD WARNING STATEMENT**

**[Arkansas, Louisiana, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia:** 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.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky:** Any person who knowingly and 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.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years. ]

**I UNDERSTAND THAT THE INSURANCE WILL BE EFFECTIVE ON THE POLICY/RIDER(S) EFFECTIVE DATE.** I, the owner, acknowledge that I saw a Quotation of Potential Policy Values only, when I applied for my new policy. I know that a complete illustration conforming to the policy as issued will be provided no later than the policy delivery if required by law.

**Producer's Statement:**

I certify that a Quotation of Potential Policy Values only was used in connection with the sale of the policy applied for, and that I have explained to the applicant that a complete illustration conforming to the policy as issued will be produced and delivered with the policy.

I further certify that I have explained that any nonguaranteed elements of the policy are subject to change. I have made no statements that are inconsistent with the illustration, which will be delivered with the policy if required by law.

**PAYROLL DEDUCTION AUTHORIZATION:** I authorize my Employer to deduct from my paycheck each pay period such sums certified to my Employer by ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York (ReliaStar Life), or it's affiliate, or their Administrator, as necessary to pay the premium due for my insurance policy(ies). I assign these sums to ReliaStar Life or their Administrator. I authorize my Employer to make future changes in payroll deduction resulting from changes in my ReliaStar Life insurance coverage.

<b>Proposed Effective Date</b> (Month, Day, Year):	<b>Amendments, Corrections and Notations made by Home Office:</b>	
Signed at (City & State):	On (Month, Day, Year):	Signature of Proposed Owner (Employee):
Producer's Name (please print):	Signature of Proposed Insured Spouse:	
Producer's License Number:	Signature of Parent or Guardian:	
Signature of Producer:	Signature(s) of Proposed Insured Children age 18 and Older:	
Remarks or Special Requests:		

SERFF Tracking #:

MNNP-128703340

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

ReliaStar Life Insurance Company of New York

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

UNI2 App MIB

Project Name/Number:

MIB/

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR_RLNYFlesch_Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Application attached under Form Schedule tab		

		Item Status:	Status Date:
Satisfied - Item:	Cover letter		
Comments:			
Attachment(s):			
AR cover letter.pdf			

ReliaStar Life Insurance Company of New York  
Home Office: Woodbury, New York  
Administrative Office: Minneapolis, Minnesota

## ARKANSAS COMPLIANCE CERTIFICATION

I certify to the best of my knowledge and belief that ReliaStar Life Insurance Company complies with all of the following:

Rule & Regulation 19 (Unfair Sex Discrimination in the Sale of Insurance)

Rule & Regulation 49 (Life and Health Insurance Guaranty Association Notices)

ACA 23-79-138 and Bulletin 15-2009 (Consumer Information Notice)

In regard to ACA 23-80-206 (Flesch Certification):

I certify that form(s) UNI2-RL-1000-MULTI-MIB has(have) achieved a Flesch Reading Ease Score of 50.3 and comply(ies) with the requirements of the Life and Disability Insurance Policy Language Simplification Act:



---

Susannah Saver-Patterson  
Assistant Secretary

October 1, 2012

Date

**ReliaStar Life Insurance Company**  
20 Washington Avenue South  
Minneapolis, MN 55401  
Tel.: 612.372.1132  
Fax: 612.342.3695  
Email: cynthia.brasch@us.ing.com

C.T. Brasch  
Senior Compliance Analyst

October 1, 2012

Arkansas Commissioner of Insurance

Re: ReliaStar Life Insurance Company  
NAIC #: 0229-67105, FEIN 41-0451140  
ReliaStar Life Insurance Company of New York  
NAIC #: 0229-61360, FEIN 53-0242530

Life Insurance Application Form #: UNI2-RL-1000-MULTI-MIB

We are submitting the above captioned form for your review and approval. With the exception of updated language added to the Authorization/Acknowledgment section, this form is identical to form UNI2-RL-1000 approved by your Department on July 3, 2008.

As a member of MIB, Inc., formerly known as Medical Information Bureau, Inc., we support its efforts to align its practices with state and federal privacy laws. To do this, effective January 1, 2013, MIB is requiring all members to supplement their authorizations relating to MIB in order to elicit the proposed insured's express written consent to report personal health information to MIB. In this application Medical Information Bureau, Inc. has been replaced with MIB, Inc. and the following sentence added: "***I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons.***" in order to meet MIB requirements. These are the only revisions made to the previously approved version of this application.

This application will be used with our Universal Life Insurance Policy Form #: RL-UL3-POL-07 or our Whole Life Insurance Policy Form #: RL-WL2-POL-07, both of which are approved for use in your state. This form will also be used for reinstatements and/or increases of previously approved whole life and universal life insurance policy forms, including: RL-WL-POL-01 and RL-ULU-1000-98 underwritten by ReliaStar Life Insurance Company, and B-ORD-2100-93, B-ULU-1100-90 and B-ULU-1195-90 underwritten by ReliaStar Life Insurance Company of New York. ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York are affiliated companies. As part of an intercompany agreement, ReliaStar Life Insurance Company provides services for ReliaStar Life Insurance Company of New York.

This application may be in written or electronic format. For electronic enrollments, the actual wording of the statements and questions will not change, but based on responses, they may appear in a different order. Logic will be built into the electronic system to allow only the applicable information and questions to appear to the applicant. For paper enrollments, our licensed insurance agents will be trained on how to properly complete the application for each type of insurance. The fraud warnings are marked with variable brackets as the language in these warnings changes from time to time for various states and we would like the flexibility to update this language as required without having to re-file. We also have variable brackets around [WEEKLY] when used with premium. We would like to be able to customize this entry based on the applicant's pay mode as our products are voluntary products sold at the worksite and most are paid via payroll deduction.

I certify that the only revisions made to our previously approved form are those related to MIB under Section G of this application. 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. Please contact me at the number listed above if you have any questions or if you need any additional information in order to complete your review.

Very truly yours,

*C.T. Brasch*

