Group Term Life Application for Seniors

ALABAMA STATE BAR

Please complete the entire application. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to* **Insurance Specialists, Inc. - P.O. Box 2327 - Beaufort, SC 29901**

1 Tell us about yourself

Name of Association

ISI Insurance Trust	**Policy number:**

Member Name *(last, first, middle)*			
Date of Birth	Social Security Number	☐ Female ☐ Male	
Spouse's Name *(last, first, middle)*			
Date of Birth	Social Security Number	☐ Female ☐ Male	
Address			
City		State	ZIP
Home Phone	E-mail Address		

- Check life insurance plan(s) desired:
  a) Coverage for Member? ☐ $50,000 ☐ $25,000 ☐ $10,000
  b) Coverage for Spouse? ☐ $50,000 ☐ $25,000 ☐ $10,000

	Member	**Spouse**
• Have you used tobacco products of any kind in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
• Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please explain: _____

2 Beneficiary information

List one or more beneficiaries below. List the percent each will receive. The total for Member must equal 100 percent and the total for Spouse must equal 100 percent.

Beneficiary for Member Coverage	Address	Relationship	Percent
Beneficiary for Spouse Coverage	Address	Relationship	Percent

ReliaStar Life Insurance Company • Box 20 • Minneapolis, MN 55440

Please complete and sign back of application.

3 Provide us with this health information

	Member	Spouse
a.) In the past 2 years, have you consulted a doctor or had treatment for any of the following: heart disease, stroke, cancer, seizures, emphysema or other lung disease, liver disease or disorder, abnormal bleeding, diabetes, kidney disease or failure, loss of memory, Alzheimer's disease or other neurological disorder, alcohol, drug or narcotics use, an organ transplant, AIDS or other immune disorder, or ever tested positive for an HIV antibody?	☐ Yes ☐ No	☐ Yes ☐ No
b.) In the past 2 years have you consulted a doctor or had treatment for high blood pressure (excluding controlled high blood pressure defined by no readings above 145/95), other circulatory disease, or mental/nervous disorder that requires more than 1 medication to effectively treat?	☐ Yes ☐ No	☐ Yes ☐ No
c.) In the past 2 years, have you been hospitalized or confined (or been advised by a doctor to be hospitalized or confined) to a hospital, rest home, nursing home, hospice, convalescent home, extended care facility or special treatment facility?	☐ Yes ☐ No	☐ Yes ☐ No
d.) Do you need personal or mechanical assistance in walking, bathing or dressing?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to questions a - d, please give full details below:

Q#	Member or Spouse	Condition/illness/injury, type of treatment, and current status	Date(s) of treatment

4 Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

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.

Member Signature	Date Signed

Spouse Signature *(if applying)*	Date Signed