AOPA
your freedom to *fly*

50+ GROUP TERM LIFE APPLICATION

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to AOPA Insurance Administrator, P.O. Box 14464, Des Moines, IA 50306-8993

00437-Q 090084010303 Policy No. 66702-1

1. TELL US ABOUT YOURSELF

Member's Information (complete this section only if applying for Member coverage on this application):

Name (Last, First, M.I.) _____ Official Member # _____ ☐ Male ☐ Female

Date of Birth (MM/DD/YYYY)_____ Place of Birth_____ Social Security #_____

Address_____ City_____ State _____ Zip_____

Home/Cell Phone #_____ Work Phone #_____ Email Address _____

Spouse's[1] Information (complete this section only if applying for Spouse[1] coverage on this application):

Name (Last, First, M.I.) _____ ☐ Male ☐ Female

Date of Birth (MM/DD/YYYY)_____ Place of Birth_____ Social Security #_____

Address_____ City_____ State _____ Zip_____

Home/Cell Phone #_____ Work Phone #_____ Email Address _____

2. SELECT YOUR COVERAGE

Member: ☐ $50,000 (_0N1) ☐ $25,000 (_0H1) ☐ $10,000 (_0E1) (Eligibility: Ages 50–74)

Spouse[1]: ☐ $50,000 (_0N5) ☐ $25,000 (_0H5) ☐ $10,000 (_0E5) (Eligibility: Ages 45–74)

		Member		Spouse[1]	
		Yes	No	Yes	No
a.	In the past 2 years, have you been disabled due to sickness or injury?	☐	☐	☐	☐
b.	Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	☐	☐	☐	☐

If yes, please explain: _____

3. PROVIDE YOUR HEALTH INFORMATION

Member: Height _____ft. _____in. Weight _____lbs.

Spouse[1]: Height _____ft. _____in. Weight _____lbs.

		Member		Spouse[1]	
		Yes	No	Yes	No
1)	Have you ever been diagnosed or treated by a member of the medical profession for:				
a.	stroke, cancer/tumor, diabetes, seizures or AIDS (Acquired Immunodeficiency Syndrome)?	☐	☐	☐	☐
b.	memory loss, Alzheimer's disease, dementia, depression or any other mental/nervous disorder?	☐	☐	☐	☐
c.	disease or disorder of the heart, lungs, liver or kidneys?	☐	☐	☐	☐
d.	disease or disorder of the blood, or neurological, immune, digestive or intestinal system?	☐	☐	☐	☐
2)	Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?	☐	☐	☐	☐

PROVIDE YOUR HEALTH INFORMATION (CONTINUED)

		Member		Spouse[1]	
		Yes	No	Yes	No
3)	In the past 2 years, have you been hospitalized or admitted to a medical care facility (or been advised by a member of the medical profession to do so), or had medical tests, procedures or treatments recommended by a member of the medical profession that have not yet been performed?	☐	☐	☐	☐
4)	Do you receive in-home medical care or need personal or mechanical assistance in walking, bathing or dressing?	☐	☐	☐	☐

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

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	☐ Member ☐ Spouse[1]				
	☐ Member ☐ Spouse[1]				
	☐ Member ☐ Spouse[1]				
	☐ Member ☐ Spouse[1]				

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, Social Security Number, and Phone Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Attach additional sheets if necessary.

Beneficiary for Member Coverage (complete this section only if applying for Member coverage on this application)

Name (Last, First, M.I.) _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number _____ Relationship _____ Percent _____

Address _____ City _____ State _____ Zip _____ Home/Cell Phone # _____

Name (Last, First, M.I.) _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number _____ Relationship _____ Percent _____

Address _____ City _____ State _____ Zip _____ Home/Cell Phone # _____

Beneficiary for Spouse[1] Coverage (complete this section only if applying for Spouse[1] coverage on this application)

Name (Last, First, M.I.) _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number _____ Relationship _____ Percent _____

Address _____ City _____ State _____ Zip _____ Home/Cell Phone # _____

Name (Last, First, M.I.) _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number _____ Relationship _____ Percent _____

Address _____ City _____ State _____ Zip _____ Home/Cell Phone # _____

5. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have 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 Insurance Company.

Authorization and Acknowledgment — Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, pharmacy prescriptions or prescription records or any non- medical information, including motor vehicle records, as they apply to any person who is to be covered. 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 to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth 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 authorization 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 understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional 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 the 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 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

[1]Reference to Spouse includes New Jersey civil union partners as well as partners in same-sex relationships formed in other jurisdictions that provide substantially all of the rights and benefits of marriage but which may have been formed under a different name.

Any person who includes any false or misleading information on an application for coverage under an insurance policy is subject to criminal and civil penalties.

X _____ _____

Member's Signature (always required) Date

X _____ _____

Spouse's[1] Signature (if applying) Date

Questions?

Call Toll-Free: 1-844-304-AOPA (2672)
Email: aopa.service@mercer.com

ReliaStar Life Insurance Company, Minneapolis, MN