

Group #123731
Account # _____

Life Insurance Evidence of Insurability Form

Use this form if applying for life insurance that requires approval from ReliaStar Life Insurance Company

- Type or print clearly in ink.
- Also complete the **Life Insurance Enrollment Form** if you're enrolling within 60 days of eligibility
- Also complete the **Life Insurance Change Form** if you're enrolling after 60 days of initial eligibility and requesting coverage that requires approval from ReliaStar

SECTION 1: EMPLOYEE INFORMATION

Social Security Number (required)		Employee Last Name		First Name	Middle Initial	Employee I.D. Number	
House Number	Street Address			Apt/Unit Number		Birth Date (Mo/Day/Yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	ZIP Code + 4	Phone: Work ()		Home ()		Agency Code

SECTION 2: EVIDENCE OF INSURABILITY INFORMATION

EMPLOYEE: Complete only when applying for or increasing Part C or Part D more than 60 days after original insurance eligibility date, OR when applying for more than \$50,000 Part D within 60 days of original eligibility date.

SPOUSE/QUALIFIED PARTNER: Complete only when applying for Part B Basic Spouse or Part B Supplemental Spouse Life more than 60 days after original insurance eligibility date, OR when applying for more than \$25,000 Part B Supplemental Spouse Life within 60 days of original insurance eligibility date.

Spouse/ Qualified Partner Name _____ Birth Date _____ Sex ____ Marriage/Qualified Partnership Date _____

Are you a state employee? Yes No If yes, are you also applying for coverage through your agency? Yes No

Answer questions #1-7 below **only** as they pertain to the person(s) requesting coverage **AT THIS TIME**. Please provide details below for any "yes" answers. **Use a separate sheet if necessary.**

		Employee	Spouse/ Qualified Partner	
1. What is your height and weight?		Ht_____ Wt_____	Ht_____ Wt_____	
2. Have you had any injury, illness or condition, or have you consulted or been treated by a health care provider for any reason in the past 5 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever had or been treated for any of the following? Lung disorder; high blood pressure; heart trouble; stroke; diabetes; cancer/tumor; liver or intestinal disorder; kidney disorder; reproductive system or prostate disorder; depression or anxiety; arthritis, memory/concentration problems, or any physical/mental impairment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. 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)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Have you 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Do you take regular medication for treatment or control of any condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Do you contemplate any operation or visit to a health care provider for any existing condition (including pregnancy)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q#	Name of Family Member	Condition/Illness/Injury and Type of Treatment	Date of Treatment	Physician's Name and Complete Mailing Address

SECTION 3: AUTHORIZATION AND ACKNOWLEDGEMENT—Please read and sign below.

By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of Public Employees Benefits Board (PEBB) benefits.

For any medical provider, facility, insurance company, Medical Information Bureau (MIB) Inc., or employer: I give my permission for you to give ReliaStar Life or its authorized representatives ALL INFORMATION on my behalf except as stated below. This can include findings on medical care or any non-medical information that applies to me, my spouse, or my qualified domestic partner. I also permit ReliaStar Life to get investigative or consumer reports about the same people.

I declare that I have read ReliaStar Life's Insurance Information Practices Notice on the back of this form. I allow ReliaStar to disclose this information to its affiliates (including consumer reporting agencies and MIB, Inc.) to verify my/our insurability. I know that my/our medical records may be protected by federal regulations—42CFR Part 2.

I can cancel this authorization at any time, as it applies to information protected by these federal regulations, but not after ReliaStar Life or its affiliates has taken action based on this information.

I understand that my additional written consent will be required before any information 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.

As it relates to the incontestability clause, this form will be valid for 30 months from the date below or two years from the coverage effective date, whichever is earlier. I have a right to get a copy of this form; a photocopy is as valid as the original. I allow my employer to deduct money from my earnings to pay for any optional insurance I requested and approved by ReliaStar Life Insurance Company. This form replaces all previous forms and submissions I have made for PEBB life insurance.

Date	Employee's Signature (required)	
Date	Spouse/Qualified Partner's Signature (if applying)	Spouse/Qualified Partner's Social Security Number

Mail completed form to: ReliaStar Life Insurance Company, P.O. Box 20, Route 7812, Minneapolis, MN 55440-0020 | 1-800-537-5024
HCA 50-645E (8/08)

ReliaStar Life Insurance Company

Insurance Information Practices Notice

We are pleased to provide you with information regarding this Evidence Form. This information is provided to you in accordance with legislation enacted in your state.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you qualify for the coverage you requested. We review all of the information in this Evidence Form, and if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your Evidence Form is our main source of information. But we may:

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

Information Use

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

Information Maintenance and Disclosure

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

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice about MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to the MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.