

INDIVIDUAL TERM LIFE INSURANCE APPLICATION

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401

Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203

A member of the ING family of companies ("the Company")

This application may not be used if the policy to be purchased is or may be used for the benefit of a third party (a "stranger") that lacks an insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company opposes stranger-owned/stranger originated life insurance transactions ("STOLI") and will seek to terminate any such insurance coverage while retaining premiums paid, costs and/or damages. Material misrepresentation regarding the facts presented to the Company for underwriting the application or attempts to defraud the Company may result in additional legal action. Please see Section Q of the application.

A. PRODUCT INFORMATION (This application is for use with term products only.)

1. Product Requested _____ 2. Face Amount \$ _____

3. Initial Term Period: [] 10 Year (not available with all products) [] 15 Year [] 20 Year [] 30 Year [] Other _____

B. RIDER INFORMATION (Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)

[] Accidental Death Benefit Rider \$ _____ [] Waiver of Premium Rider
[] Children's Insurance Rider [] Other _____
(Complete Children's Insurance Rider Application.) [] Other _____

C. PROPOSED INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____

2. Birth Date _____ Birth State/Country _____ Gender: [] Male [] Female

3. E-mail _____ SSN or Government Issued ID Number _____

4. Daytime Phone (_____) _____ Evening Phone (_____) _____ Best Time to Call _____

5. Residence Address (PO Boxes are not permitted.) _____
City _____ State _____ ZIP _____

6. Are you a U.S. Citizen? (If "No", complete the Foreign Travel and Residence Questionnaire.) [] Yes [] No

7. Occupation/Duties _____

8. Employer _____ Employer Phone (_____) _____

9. Employer Address _____

10. Do you currently or have you ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches) [] Yes [] No

If "Yes", indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

11. Driver's License Number _____ 12. Driver's License State _____
(if you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)

13. Name on Driver's License (if different than above) _____

D. OWNER (If Proposed Owner is a Trust or Corporation, provide first and last pages of the Trust document, including signatures. The Trust must be established prior to the application date.)

1. Full Name of Owner/Trust/Corporation (30 character limit) _____

2. Owner Relationship to Proposed Primary Insured _____

3. Owner Birth Date _____ Owner Phone (_____) _____ Owner SSN/TIN _____

4. Owner Address (PO Boxes are not permitted.) _____

5. Corporation Contact Name _____

6. Address of Trust/Corporation _____

7. Billing Address _____

D. OWNER (Continued)

8. Type of Government Issued ID (Driver's License/Passport) _____ Document Number _____
 Issuing State or Country _____ Issuance Date _____ Expiration Date _____
9. Trust Contact Name _____ TIN _____ Trust Date _____
10. Purpose of the Trust _____ Type of Trust: Revocable Irrevocable
11. State of Incorporation _____ Trustee/Corporate Officer Name _____
12. Does the above trustee have sole authority to act on behalf of the Trust? Yes No
 (If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees on the application.)

E. PAYOR (Complete only if the payor is to be other than the owner.)

1. Payor Name _____
2. Payor Address (PO Boxes are not permitted.) _____

F. BENEFICIARY INFORMATION (Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)

1. Is the Beneficiary a Trust? Yes No
2. Trust/Corporation Name _____ Trust Date _____ State of Incorporation _____

| Name (First, MI, Last) | Birth Date | Gender | SSN | Relationship | % | Beneficiary Type |
|------------------------|------------|--|-----|--------------|---|---|
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent |

G. PROPOSED INSURED PERSONAL HISTORY

1. Are you, or have you entered into a written agreement to become, a member of the armed forces, including the Reserves, or on alert? (If "Yes", complete Military Questionnaire.) Yes No
2. Do you intend to travel or reside outside the United States or Canada in the next two years? (If "Yes", complete Foreign Travel and Residence Questionnaire.) Yes No
3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? (If "Yes", complete Aviation Questionnaire.) Yes No
4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? (If "Yes", complete Avocations and Professional Sports Questionnaire.) Yes No
5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes or dune buggies? (If "Yes", complete Motor Sports Questionnaire.) Yes No
6. Except for traffic violations, have you been convicted in a criminal proceeding or are you the subject of a pending criminal proceeding? Yes No
7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? Yes No

For any "Yes" answer to questions 6-7, please record information in the chart below.

| Question | Explanation |
|----------|-------------|
| | |
| | |
| | |

H. PAYMENT INFORMATION

- 1. Initial Payment Amount \$ _____ Initial Payment: Check Cash on Delivery Credit Card EFT
- 2. Subsequent Payment Amount \$ _____ Subsequent Payments Frequency: Annually Semi-Annually Quarterly Monthly²
- Military Allotment³ (Active or retired military members must complete the Military Allotment form and return it to the military finance department.)
- Civil Service Allotment (The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)

¹ To draft the initial premium payment, complete Appendix E.
² To draft monthly payments, complete Section B of Appendix E.
³ Two monthly premium payments are required before the policy becomes active.

I. AUTOMATIC PREMIUM LOAN (APL) (Available with Endowment Benefit Products only.)

If you elect the APL Option, you direct the Company to pay premiums due but not paid by the end of the grace period by taking a loan against any available Loan Value. If the available Loan Value is not sufficient to pay the premium then due, the policy may terminate.

I elect the Automatic Premium Loan (APL) Option

J. FUNDED ERISA INFORMATION (Complete if the policy will be owned by a "Funded ERISA Plan".)

Is the insurance for a tax-qualified, pension, profit sharing or defined contribution ERISA plan, or a VEBA or welfare benefit arrangement? . . . Yes No

Plan Provider Name _____

- Tax-qualified plan (specify profit sharing, defined benefit, or defined contribution) _____
- Section 419/419A(f)(6) welfare benefit or VEBA plan Other (specify type and name of plan) _____

K. LIST BILL INFORMATION - EMPLOYER-SPONSORED PLANS ONLY (For a new List Bill plan, please contact the List Bill Department at 877-886-5050.)

- 1. Is the insurance employer-sponsored? Yes No List Bill/File Code Number (if plan already exists) _____
- 2. Employer Plan Name (if plan already exists) _____ 3. Phone (_____) _____
- 4. Address _____

L. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? Yes (If "Yes", review the policy backdating notice below.)

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

I understand, on backdated policies, that the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

M. FINANCIAL DETAILS

- 1. Is the applied-for policy in accordance with your insurance objectives and your anticipated financial needs? Yes No
- 2. Do you believe you have the financial ability to continue making premium payments on this policy? Yes No
- 3. Have you or your company ever declared bankruptcy? (If "Yes", provide details including date discharged.) Yes No

4. Personal Insurance (For Personal Insurance complete questions 4-6; for Business Insurance complete questions 7-10.)

- Estate Liquidity Family Protection Tax Planning Retirement Planning Cash Accumulation
- Other _____

5. Annual Earned Income \$ _____ Annual Interest and Other Income \$ _____

6. Total Assets \$ _____ Total Liabilities \$ _____ Total Net Worth \$ _____

7. **Business Insurance:** Buy/Sell Key Person Other _____

8. Total Business Assets \$ _____ Total Business Liabilities \$ _____ Total Business Net Worth \$ _____

9. Business Net Profit After Taxes for Past Two Years: Last Year \$ _____ Previous Year \$ _____

M. FINANCIAL DETAILS (Continued)

| 10. Business Owner Name | Title | Amount of Business Coverage in force | Percentage of Ownership | Active in Business? |
|-------------------------|-------|--------------------------------------|-------------------------|--|
| | | \$ | % | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | \$ | % | <input type="checkbox"/> Yes <input type="checkbox"/> No |

N. IN FORCE/REPLACEMENT INFORMATION (Applies to both Owner and Proposed Insured. If a replacement is occurring, the owner is required to terminate the existing policy with a separate written request to the insurance provider.)

1. Do you currently have life insurance in force or applied for? (If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)

Proposed Insured: Yes No | Proposed Owner: Yes No

| Insured Name | Insurance Company (Do not include group policies.) | Policy Number | Amount | Date Issued |
|--------------|--|---------------|--------|-------------|
| | | | \$ | |
| | | | \$ | |
| | | | \$ | |
| | | | \$ | |

2. 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 below.)

Proposed Insured: Yes No | Proposed Owner: Yes No

3. 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 below.)

Proposed Insured: Yes No | Proposed Owner: Yes No

4. For any "Yes" answer to questions 2-3, provide details regarding the policies being replaced in the chart below.

| Insured Name | Insurance Company | Policy Number | Amount |
|--------------|-------------------|---------------|--------|
| | | | \$ |
| | | | \$ |
| | | | \$ |
| | | | \$ |

O. MEDICAL TRANSFER STATEMENT (Complete when submitting medical examinations from another insurance company.)

1. Insurance Company Name _____ 2. Examination Date _____

3. To the best of your knowledge and belief, are the statements in the above examination true and complete today?

Proposed Insured: Yes No | Proposed Owner: Yes No

4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 2 above? (If "Yes", please provide details below.)

Proposed Insured: Yes No | Proposed Owner: Yes No

P. REPLACEMENT VERIFICATION (For Agent use ONLY. If a replacement is occurring, the owner is required to terminate the existing policy with a separate written request to the insurance provider.)

1. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? (If "Yes", submit state required replacement forms.) Yes No
- a. Is the applicant considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating their existing policy or contract? (If "Yes", complete state required replacement form and provide details below.) . . . Yes No
- b. Is the applicant considering using funds from their existing policies or contracts to pay premiums due on the new policy or contract? (If "Yes", complete state required replacement form.) Yes No

Company _____ Policy Number _____ Amount \$ _____

Q. ING'S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI)

The Company, along with other ING Life Companies strongly opposes arrangements designed to obtain life insurance for the benefit of a third party (a "stranger") that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. We believe this position supports the best interests of our policy owners, as stranger-owned or stranger-originated life insurance transactions ("STOLI") will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business. The Company will seek to terminate the insurance coverage under any contract determined to be STOLI or where material misrepresentation has occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

The Company does not sell life insurance in the following circumstance:

- If, at the time of sale or conversion, the applicant/owner has an intent, plan, arrangement or understanding with a third party that will result directly or indirectly in the sale, assignment, settlement or other transfer to an investor, such as a life settlement company, or any other party with no insurable interest in the life of the insured who purchases the policy for investment purposes;
- If, at the time of sale or conversion, the applicant/owner has an intent, plan or arrangement to transfer an ownership interest or beneficial interest in an entity that will own the policy to a life settlement company or any other party with no insurable interest in the life of the insured;
- If, in connection with the sale, the applicant/owner and/or the insured is offered any compensation, reward or benefit, or other inducement to purchase or assist in the purchase the policy, including, but not limited to, cash payments, property such as a life insurance death benefit for "free" or at "no cost" or any other benefit of any kind;
- Where a sales concept, design, marketing plan, marketing material or other program that has not been disclosed to the Company is used in connection with the sale (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending arrangement where the lender's sole collateral for the premium loan is limited to the values of the policy itself);
- Where the producer and/or applicant knows, or has reason to know, that the source of funds for premium payments under a policy has not been disclosed to the Company (including, but not limited to, any arrangement to pay for premiums under the policy through a loan through a premium financing arrangement or other third party funding) ; or
- In any other circumstance determined by the Company, in its sole discretion, to be inconsistent with our policies on STOLI, insurable interest or misrepresentation.

The activities described above are considered "prohibited conduct".

R. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION

Representations and acknowledgements: By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and represent that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the Application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. Unless otherwise stated in a Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, and the first premium is received by the Company while the Proposed Insured is alive. If I have paid premium with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

R. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION (Continued)

By my signature below, I affirmatively warrant and represent that I have not engaged in any prohibited conduct described in Section Q above in connection with this application for insurance.

Authorization and Statements of Understanding: I authorize the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original.

I acknowledge receipt of the following disclosures and notices: Accelerated Benefit Rider and Critical Illness Disclosures, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. I certify, under penalty of perjury, that my Social Security Number/tax identification number is shown and is correct and that I am not subject to back-up withholding.

If an investigative consumer report is prepared, I request to be interviewed. Yes

Daytime phone number: () _____

Contact me between the hours of ___ a.m./p.m. and ___ a.m./p.m.

By my signature below I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:

Governing Law. The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

Jurisdiction. Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

All completed materials must be sent to the ING Customer Service Center at: 2000 21st Ave. NW, Minot, ND 58703

I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

Proposed Owner Signed at (city/state) _____ Date _____

➡ Proposed Owner Signature (if other than the Insured) _____

Proposed Owner/Trustee Name (please print) _____

➡ Proposed Insured Signature _____ Date _____
(if other than the owner & age 15 or older)

➡ Parent or Guardian Signature _____ Date _____
(if the Proposed Insured is a minor)

By signing below I acknowledge that I have not engaged in prohibited conduct as described in Section Q, "ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI)," nor am I aware of such conduct by the applicant

➡ Writing Agent Signature _____ Date _____

Writing Agent Name (please print) _____

Writing Agent State Lic. Number _____ Writing Agent Number 855V879

TEMPORARY INSURANCE RECEIPT

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401
 Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203
("the Company")



I. PREMIUM RECEIPT *(On the lives of the Proposed Primary Insured and Proposed Other Insured named below)*

Amount Received \$ _____ Date _____ Policy Application Date _____

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS *(For each Proposed Insured named below)*

- Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
 - any type of heart disease, stroke or other vascular disease? Yes No
 - any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system? Yes No
- In the past five years has any Proposed Insured experienced unintentional weight loss? Yes No
- Has any Proposed Insured attained age 70? Yes No

III. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders covering the life or lives of the Proposed Insured(s) if issued as applied for under the Application; or (b) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage.

If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the issue date, premiums are due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.

There is no temporary insurance receipt coverage if:

- Any of the above representations is answered YES or LEFT BLANK.
- If Section 1035 exchange paperwork is received without premium payment.
- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury. (This suicide clause does not apply in the state of Missouri.)
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name *(please print)* _____ Signed at *(city/state)* _____

➔ Proposed Owner Signature _____ Date _____

Proposed Insured Name *(please print)* _____ Signed at *(city/state)* _____

➔ Proposed Insured Signature *(if other than the Proposed Owner)* _____ Date _____

Proposed Other Insured Name *(please print)* _____ Signed at *(city/state)* _____

➔ Proposed Other Insured Signature _____ Date _____

Writing Agent Name *(please print)* _____ Agent Phone (713) 621-1440

➔ Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE CENTER 2ND COPY TO PROPOSED INSURED

AGENT'S REPORT

To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.

| Agent Name/Broker-Dealer (please print) | Agent ID Number | % Split | General Agent Number | General Agent Name |
|---|-----------------|---------|----------------------|--------------------|
| | 855 V879 | | | |
| | | | | |
| | | | | |

A. COMPLIANCE INFORMATION

- Did you meet personally with the Proposed Owner and review their government issued ID? (If "No", explain in Section D.) Yes No
- Did you obtain the Proposed Insured's Medical Declarations in person and record them in the presence of the Proposed Insured? (If "No", explain in Section D and arrange for an exam.) Yes No
- Was an initial premium payment accepted? Yes No
If "Yes", was the Temporary Insurance Receipt completed and delivered to the Proposed Insured or Proposed Owner? Yes No
- Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? Yes No
- Has the Proposed Owner or Proposed Insured previously sold or assigned a policy to a life settlement or viatical company? Yes No
If "Yes", provide details.
- Will financing (using any source other than the client's assets) of premium payments be used now or is it contemplated within the next two years? Yes No
a. If "Yes", complete the Financing Disclosure & Acknowledgment.
b. If "No", what is the source of funds used to pay premiums on this policy? (Check all that apply below.)

| | Initial | Future |
|--|--------------------------|--------------------------|
| Current income | <input type="checkbox"/> | <input type="checkbox"/> |
| CDs or savings | <input type="checkbox"/> | <input type="checkbox"/> |
| Mutual funds or brokerage account | <input type="checkbox"/> | <input type="checkbox"/> |
| Existing life insurance policy(ies) or annuity contract(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

B. PROPOSED INSURED/OWNER INFORMATION

- How long have you known the Proposed Insured? _____ 2. Are you related? Yes No How? _____
- How much life insurance is in force on the Proposed Insured's spouse/domestic partner, payable to the Proposed Insured or other dependents? \$ _____
- What is the annual income of the Proposed Insured's spouse or domestic partner? \$ _____
- If this application is for a juvenile, indicate the amount of life insurance in force on each parent or sibling.
Father \$ _____ Mother \$ _____ Sibling \$ _____
- If underwriting requirements were ordered, which paramedical vendor was used? _____

C. RELATED APPLICATIONS (List all applications that are concurrently being submitted to ING for the Insured's family members and/or business partners.)

Proposed Insured Names and Amounts applied for _____

D. REMARKS (Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.)

E. ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent Producer or other agent agreement ("Agreement"), including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker/Dealer and do not hold an Agreement such that this language is inapplicable. I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

I certify that all sales materials used during this sale were approved by the Company. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Company's corporate policy. I acknowledge that I have delivered the Important Notices (Consumer Privacy Notice & MIB) to the Proposed Insured(s) or Proposed Owner. I affirm that the answers above are complete and true to the best of my knowledge and belief.

Agent Signature(s) _____ Date _____

Contact for Requirements _____ Agent SSN (Optional - Last 4 digits only) _____

Agent Phone 713 621-1440 Fax 877-718-8056 E-mail stevew@selectedbenefits.com

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization is HIPAA compliant.

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(please print)* _____

Birth Date _____ SSN/TIN _____

Proposed Insured/Patient Address _____

City _____ State _____ ZIP _____

AUTHORIZATION INFORMATION

This will authorize: _____ *(Physician, Clinic or Hospital Name)*

to release medical information to _____ *(the Life Insurance Agent/Agency).*

Authorized Life Insurance Carrier(s) _____

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, according to the terms of this authorization. This includes any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Agent/Agency named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Agent/Agency may provide the information to the listed carrier(s) so that they may: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Agent/Agency.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Agent/Agency named above at the following address.

Attention: Privacy Official

Agency Address _____

City _____ State _____ ZIP _____

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

➔ Proposed Insured/Patient or
Personal Representative Signature _____ Date _____

Description of Personal Representative's
Authority or Relationship to Patient *(please print)* _____

A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PROPOSED INSURED/PROPOSED OTHER INSURED.

CREDIT / DEBIT CARD PAYMENT AUTHORIZATION AND ELECTRONIC FUNDS TRANSFER

ReliaStar Life Insurance Company, 20 Washington Avenue South, Minneapolis, MN 55401

Security Life of Denver Insurance Company, 1290 Broadway, Denver, CO 80203

("the Company")

A member of the ING family of companies

ING Customer Service Center, 2000 21st Ave. NW, Minot, ND 58703



Your future. Made easier.®

The first premium payment will be applied when all policy requirements have been received. A specific draft date for subsequent premium payments can be requested, however, it may cause multiple drafts within the first 30 days.

A. CREDIT/DEBIT CARD PAYMENT AUTHORIZATION *(This is available for all Term Products except in Maryland, New York and North Carolina¹.)*

Request and Authorization for Credit/Debit Card Payment of Initial Premium: The Company is hereby requested and authorized to initiate a credit/debit card transaction to be charged against the account described in the Authorization below for the **initial payment only**. Subsequent premium payments will be made either by direct billing or EFT.

| Insured Name <i>(please print)</i> | Policy Number | Payment Amount |
|------------------------------------|---------------|----------------|
| | | \$ |
| | | \$ |
| | | \$ |
| | | \$ |

Premium Payment Mode: Monthly Quarterly Semi-Annually Annually

Full Name *(Print as it appears on card.)* _____

Account Number *(16 digits)* _____ Expiration Date *(month and year)* _____

Billing Zip Code _____ Credit/Debit Card Type: MasterCard Visa Discover

I authorize the Company to charge my initial insurance premium for the policy numbers listed above, to the credit/debit card account I have indicated. I understand that this payment will be for the initial premium only, and that I will either be billed for subsequent payments directly or by EFT if I have indicated so on previous pages of this application.

➔ Cardholder Signature² _____

¹In NC only debit cards are allowed to be used. Credit card usage is prohibited.

²Payment cannot be processed without signature.

B. ELECTRONIC FUNDS TRANSFER

What is the EFT plan?

The EFT plan allows us to pay your policy premiums by automatically withdrawing funds from your financial institution's account.

What happens if my financial institution does not honor a withdrawal?

If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. Premium payments are necessary to fund your policy; therefore, you will be required to send us a replacement payment. If we do not receive a replacement payment within the time required by your policy, your policy will enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage. To help prevent this, we encourage you to obtain overdraft protection from your bank.

How much will be deducted from my account?

We will only deduct premium payments according to the payment schedule outlined in your policy.

How can I cancel the EFT plan?

You have two options. You can write to us as the address above. Once we receive your request, we will cancel the plan within 7 – 10 business days. You may also call us at 877-886-5050 to cancel the plan.

We may cancel the plan without notice if a withdrawal is not honored or 30 days after we provide written notice to you.

If the plan is cancelled, you must pay any unpaid and future premiums directly to us on the premium due date. Termination of the plan does not change the premium due dates.

I'd like to enroll. Where do I sign?

Please read the following agreement and sign and date this form.

Authorization Agreement for Prearranged Payments

I authorize the Company to withdraw funds from my checking or savings account, identified on the next page, to pay premiums on my life insurance policy. This authorization will remain in effect until the Company has received a written request or phone call from me to terminate this agreement.

B. ELECTRONIC FUNDS TRANSFER (Continued)

Please Note: Premiums paid more frequently than annually may result in higher total premiums for the same coverage, depending on the product specifications.

This agreement authorizes: A new transfer A change in existing transfer amount A change in financial institution

Payment Frequency: Monthly Quarterly Semi-Annually Annually (Frequency other than monthly depends on the policy type.)

| Insured Name (please print) | Policy Number | Deduction |
|-----------------------------|---------------|-----------|
| | | \$ |
| | | \$ |
| | | \$ |
| | | \$ |

Request Specific Draft Date for Recurring Payments² (Between the 1st and the 28th) _____

Bank Name _____ Account Type: Checking Savings

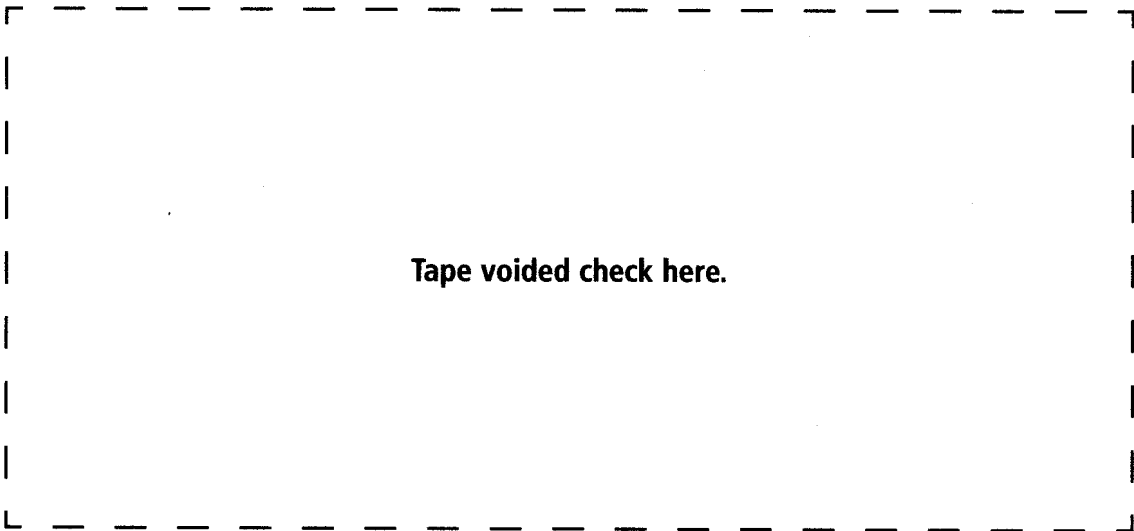
Bank Address _____

City _____ State _____ ZIP _____


Name(s) on Account _____

² Depending on the type of policy you own, the draft date options may vary. Please call us at 877-882-5050 option 1, option 1 for more information.

For checking accounts, please tape a voided check in the space below. If you cannot provide this, you may write the bank routing number and account number in the appropriate fields.

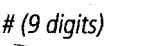



Routing Number (9 digits) _____ Account Number _____


 Account Owner Signature _____ Date _____

SSN/TIN _____ Phone (____) _____

Sample Check

Routing # (9 digits) 

| | | | | | |
|---|---------------|------------|--|----------------|--|
|  | | MEMO _____ | | Not Negotiable | |
| 987654321 | 1234567890123 | 5678 | | | |

Account # 



ReliaStar Life Insurance Company
Home Office: Minneapolis, MN
Administrative Office:
P.O. Box 5075
Minot, ND 58702-5075

LIVING BENEFIT RIDER DISCLOSURE STATEMENT

The accelerated benefit rider, better known as ReliaStar's Living Benefit Rider, allows the owner to access a portion of the life insurance death benefit if the insured becomes terminally ill (life expectancy of 6 months or less as determined by a physician). The benefit is always payable to the owner.

There is no additional premium required to issue this rider. If you request an accelerated benefit, an interest charge and an administrative expense charge will be deducted from the amount you request.

When an accelerated benefit is paid, the death benefit, cash values and loan values of the policy will be reduced proportionally. The amount will be determined at the time you request a Living Benefit payment.

For example, suppose you purchase a policy with a \$100,000 death benefit. Later, you request a Living Benefit payment of \$25,000. Any charges noted above would be deducted from the \$25,000 and the resulting total would be your Living Benefit payment. The death benefit on your policy would then be reduced to \$75,000, and any required premium would be reduced proportionally. If your policy has cash values, those accumulations would also be reduced proportionally.

Limitations of the Accelerated Benefit:

- (a) The rider is not intended to replace health or disability coverage. Rather, it provides an added source of funds to meet critical needs during a difficult time. You choose how the funds will best meet your needs. There are no restrictions on how a Living Benefit payment can be used.
- (b) Accelerated benefits payable under this rider may or may not be taxable. You should consult your personal tax advisor.
- (c) Receipt of accelerated benefits under this product may affect medicaid and supplemental security income ("SSI") eligibility.

If at some future point in time, you decide that you no longer wish to carry the Living Benefit Rider on your coverage, you may request that it be removed. The Living Benefit Rider will automatically terminate when the life insurance policy matures.

The Living Benefit Rider is subject to eligibility requirements.

ACCELERATED BENEFIT RIDER DISCLOSURE

ReliaStar Life Insurance Company

20 Washington Avenue South, Minneapolis, MN 55401

A member of the ING family of companies

ING Customer Service Center: PO Box 5011, Minot, ND 58703-5011



Your future. Made easier.®

READ THE RIDER CAREFULLY

Receipt of an Accelerated Benefit payment may be taxable, and assistance should be sought from a personal tax advisor. Receipt of an Accelerated Benefit payment may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

There is no additional premium required for the Accelerated Benefit Rider; instead, an actuarial discount is associated with the acceleration and an Administrative Expense Charge is assessed upon the exercise of the benefit.

- We will pay an Accelerated Benefit, at the Policy Owner's request, if the Insured has a Qualifying Condition. A Qualifying Condition is a non-correctable medical or physical condition that, with a reasonable degree of medical certainty, will result in the Insured's death in 12 months or less from the date of receipt of a Physician Statement. Refer to the Rider for more details.
- The Policy Owner may request an acceleration of a portion of the Stated Death Benefit, subject to a minimum Accelerated Benefit of \$5,000 and a maximum Accelerated Benefit equal to the lesser of 25% of the Stated Death Benefit or \$250,000. We will pay the amount requested reduced by:
 - An actuarial discount based on, (1) the annual rate of interest declared by us, and (2) the then current premium;
 - An amount equal to any current Policy loan and accrued loan interest, multiplied by the Benefit Ratio (the Benefit Ratio is equal to the amount accelerated divided by the Stated Death Benefit); and
 - An Administrative Expense Charge of \$150.

The remainder will be paid to the Policy Owner. Other conditions and limitations, as described in the Rider, may apply.

- The Accelerated Benefit will be paid in a lump sum, unless the Policy Owner requests and we agree to payment in some other manner.
- Following an Accelerated Benefit payment, the Policy's Stated Death Benefit, any Cash Value, any outstanding Policy loan, the required premium for the Policy (excluding any policy fee), and premium for any Waiver of Premium Rider (Disability) will all be reduced by the Benefit Ratio. We will mail to the Policy Owner, for attachment to the Policy, an endorsement or amended schedule page that details the changes to the Policy that result from the Accelerated Benefit payment.
- Following an Accelerated Benefit payment, this Rider will terminate. Continued premium payment is required in order to keep the Policy in force.
- If a Waiver of Premium Rider (Disability) is attached to the Policy and in force, and the Insured's Qualifying Condition began before the Policy Anniversary when the Insured reaches age 60, then after an Accelerated Benefit payment the Insured will be deemed to be Totally Disabled for as long as the Physician Statement continues to apply.

An example of the effect of an Accelerated Benefit request of \$25,000 is shown below.¹

| Before Acceleration | | Requested Acceleration = \$25,000 | | After Acceleration | |
|--------------------------|-----------|-----------------------------------|----------|--------------------------|----------|
| Stated Death Benefit | \$100,000 | Benefit Ratio | 25% | Stated Death Benefit | \$75,000 |
| Premium | \$500 | Actuarial Discount ² | \$625 | Premium | \$375 |
| Policy Loan ³ | \$6,000 | Loan Repayment ³ | \$1,500 | Policy Loan ³ | \$4,500 |
| Cash Value ³ | \$10,000 | Administrative Expense Charge | \$150 | Cash Value ³ | \$7,500 |
| | | Net Payment to Owner | \$22,725 | | |

I acknowledge that I have received and read this summary which has been furnished to me with the Policy/Rider application.

➡ Policy Owner Signature _____ Date _____

➡ Agent/Producer Signature _____ Date _____

¹This example is illustrative only and is not intended to show actual values.

²Assumes hypothetical interest rate of 5%.

³Cash Value and Policy loans, if any, are only available with the ROP Endowment Term life insurance.

IMPORTANT NOTICES**CONSUMER PRIVACY NOTICE****Notice Regarding Consumer Reports**

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, the Company ("we") will send you the name, address, and phone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records or by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with the Company unless you request otherwise.

The information may be kept by the consumer reporting agency. It may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

**Notice Regarding MIB, Inc.
(Medical Information Bureau)**

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau (MIB), Inc. MIB is a nonprofit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The mailing address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. The phone number is 866-692-6901 and the fax number is 866-346-3642. The MIB website address is www.mib.com.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Federal Regulations - 42CFR Part 2

Your medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. If information is protected by federal or state law, you may revoke this authorization at any time by mailing a written request to the Company. A written request, however, will not apply to any information collected before the date that we receive your request.

IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money-laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you apply for life insurance, we will ask for your name, address, birth date, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to:

ING Customer Service Center
Life New Business
PO Box 5053
Minot, ND, 58702-5053

This page must be given to the Proposed Insured.

VALUABLE INFORMATION ABOUT YOUR TERM LIFE INSURANCE PURCHASE

Thank you for considering the Company for your life insurance needs. Your professional insurance producer may work with many life insurance companies, and we are pleased that your producer has presented one of our products to you.

We'd like you to understand how we pay the selling producer. Producers earn a commission for each policy sold. The commission is generally a percentage of the policy premiums you pay. The percentage may be higher for producers that sell a larger number of policies. Producers may receive additional compensation for each year a policy remains in force or for achieving certain sales volume levels. The actual percentage and amount of compensation paid will vary based on the specific circumstances of your purchase.

Producers may receive additional non-cash compensation from us as a reward for things like achieving sales contest objectives or other measures. We also may pay for producer education, training or attendance at conventions, and may provide financing, or other payments or benefits. In addition, some producers may be associated with independent marketing organizations ("IMOs") that have agreements with us. IMOs provide administrative services to independent producers and marketing support for our policies. We may make payments to IMOs that may be based on the amount of premium written with us by producers associated with the IMO.

This is a general discussion of the compensation we pay for the sale of our policies. We pay commissions and other sales expenses from our general assets and revenues, including amounts we earn from fees and charges under our policies. We set the price of an insurance policy and it reflects the compensation we pay for the sale of the policies. It also covers costs we incur for the design, manufacture and service of our policies, for policy benefits and features including guarantees, and for the investment management needed to support the policies' values. We and our affiliates offer other insurance products in addition to the product you have selected. These other products may have different features, benefits, fees and charges and may provide you coverage that could meet your needs at a greater or lesser cost to you. We are committed to providing top-quality insurance products to our customers and are pleased that your professional insurance producer trusts us to deliver on your long-term insurance needs.

ACKNOWLEDGEMENTS

Notice Regarding Collection of Information and Information Practices

In order to evaluate your application for life insurance, we must collect information about you and any minor children who are to be insured. The type of information that we may collect includes, but is not limited to, the following: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information about you or your minor children who are to be insured. Some of that information will come from you. Some will come from other sources.

The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically related facilities, insurance or reinsuring companies, Medical Information Bureau ("MIB"), Inc., any consumer reporting agencies, and any other organizations. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

Proposed Insured/Owner: By signing Section R on the Individual Term Life Insurance Application, the Proposed Insured acknowledges receipt of these notices.

Producer: By signing Section R on the Individual Term Life Insurance Application, the producers acknowledge that a copy of these notices have been provided.

This page must be given to the Proposed Insured.