mncpa
Elevate your impact.

Group Term Life Application for 20-Year Level Term Rate

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ***MNCPA Group Insurance Program, P.O. Box 14533, Des Moines, IA 50306, or call 1-800-732-8350, or email customerservice.service@getamba.com.***

Minnesota Society of Certified Public Accountants **Policy No. 64269-0**

1. TELL US ABOUT YOURSELF

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

Name (Last, First, M.I.)	Name of Member	☐ Member ☐ Employee of Member	☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

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

Name (Last, First, M.I.)	Name of Member	☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number
Address	City	State / Zip
Home/Cell Phone #	Work Phone #	E-mail Address

Dependent Child(ren)'s Information ***(complete this section only if applying for Dependent Child(ren) on this application).***

Number of eligible children: ____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Address	City	State	Zip	Home/Cell Phone #

	Member/ Employee	**Spouse**
a.) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
Date of last use (month/year):	____/____	____/____
b.) Are you currently working less than 30 hours per week at your regular occupation and place of business?	☐ Yes ☐ No	☐ Yes ☐ No
c.) Will any of the life 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. SELECT YOUR COVERAGE

☐ **20-Year Level Term**

Member Amount

☐ $_____ *in $5,000 increments*
(Minimum: $100,000 Maximum: $1,000,000)

☐ **20-Year Level Term**

Spouse of Member Amount

☐ $_____ *in $5,000 increments*
(Minimum: $100,000 Maximum: $1,000,000)

☐ **20-Year Level Term**

Employee of Member Amount

☐ $_____ *in $5,000 increments*
(Minimum: $100,000 Maximum: $250,000)

Please select if you wish to include additional options with your coverage ***(If AD&D is elected, benefit will match life amount):***

☐ $10,000 Dependent Child(ren) Coverage*
☐ Member/Employee Accidental Death & Dismemberment
☐ Spouse of Member Accidental Death & Dismemberment
*If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

3. PROVIDE YOUR HEALTH INFORMATION

Member/Employee: **Height**_____**ft.**_____**in. Weight**_____**lbs.** Spouse: **Height**_____**ft.**_____**in. Weight**_____**lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member/Employee:_____ Spouse:_____

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services performed at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization (at the bottom of this application) for a definition of "Emergency Medical Personnel."

	Member/ Employee	Spouse
1.) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	☐ Yes ☐ No	☐ Yes ☐ No
2.) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack), sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?	☐ Yes ☐ No	☐ Yes ☐ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?	☐ Yes ☐ No	☐ Yes ☐ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?	☐ Yes ☐ No	☐ Yes ☐ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?	☐ Yes ☐ No	☐ Yes ☐ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?	☐ Yes ☐ No	☐ Yes ☐ No
3.) 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?	☐ Yes ☐ No	☐ Yes ☐ No
4.) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
5.) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?	☐ Yes ☐ No	☐ Yes ☐ No
6.) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?	☐ Yes ☐ No	☐ Yes ☐ No
a. Member/Employee's driver's license number and state of issue:		
b. Spouse of Member's driver's license number and state of issue:		
7.) Have you ever applied for insurance that was declined, postponed or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No
8.) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?	☐ Yes ☐ No	☐ Yes ☐ No

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/Employee ☐ Spouse of Member				
	☐ Member/Employee ☐ Spouse of Member				
	☐ Member/Employee ☐ Spouse of Member				
	☐ Member/Employee ☐ Spouse of Member				
	☐ Member/Employee ☐ Spouse of Member				
	☐ Member/Employee ☐ Spouse of Member				

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Member/Employee Coverage *(complete this section only if applying for Member/Employee 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 of Member Coverage *(complete this section only if applying for Spouse of 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 #

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

(Choose only one. Option selected is applicable to all coverages approved through this application):

☐ **Option 1:** **AUTOMATIC CHECK WITHDRAWAL REQUEST:** ☐ Monthly ☐ Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: _____ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

☐ **Option 2:** **DIRECT BILL:** ☐ Quarterly ☐ Semi-Annual ☐ Annual

Billing dates will begin after coverage is approved and initial premium has been received.

6. 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 the 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, LLC (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, or my authorized representative, have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid as long as I am continually insured with ReliaStar Life or 12 months, whichever is less. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

This authorization excludes the release of information about HIV (AIDS Virus) which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services, licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services, crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care, and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good Samaritan law.

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/Employee's Signature (always required)	Date	Spouse of Member's Signature (if applying)	Date

THIS PAGE IS INTENTIONALLY LEFT BLANK.

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a 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 MIB, LLC, formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. 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, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. 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 us. 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; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

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, LLC, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our 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 or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. 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 Regarding MIB, LLC.

We or our reinsurers may make brief reports to MIB, LLC (hereafter "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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901. 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.

THIS PAGE IS INTENTIONALLY LEFT BLANK.

Group 20-Year Level Term Life Insurance Plan

FOR MINNESOTA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS MEMBERS

- ***Level Issue Age Premiums designed to remain level for 20 Years****
- ***Level Coverage for 20 Years***

Group 20-Year Level Term Life Insurance is Protection Your Family Needs

You certainly understand the importance of having sufficient life insurance. Your loved ones will appreciate the peace of mind this Plan provides, with benefits up to $1,000,000 that will let them go on with their lives with fewer financial concerns.

About This Plan

You may apply for $100,000 up to $1,000,000 in 20-Year Level Term Life insurance coverage (in $5,000 increments). Coverage continues as long as you remain an active member of the Minnesota Society of Certified Public Accountants, pay your premium when due; and the Group Policy remains in force. Your amount of insurance will not decrease due to age during a level term rate period.

For members or spouses/domestic partners who are under age 65 at the end of a level term period, coverage will not reduce until age 65. Coverage will reduce to the lesser of 25 percent of the amount in effect prior to age 65 or $37,500. Spouse/Domestic Partner coverage terminates at age 70.

Eligibility

All MNCPA members under age 50 may apply for coverage for themselves, their spouse/domestic partner under age 50 and all unmarried dependent children ages 14 days through 19 years (23 if a full-time student).

If both member and spouse/domestic partner are covered as members, neither may insure the other as spouse/domestic partner and only one may insure any eligible children.

This coverage is available only for residents of the United States.

PLAN FEATURES

Pay Less if You're a Qualified Non-Tobacco User
Non-tobacco users meeting the highest underwriting standards may qualify for the Plan's lowest rates.

Satisfaction Guaranteed
You may return your Certificate of Insurance within 30 days if you are not completely satisfied with the coverage this Plan provides. Any premiums paid will be fully refunded provided no claims have been submitted or paid under the group policy during that 30-day period.

Convenient Payment Options
You will automatically be billed on a semiannual basis. However, there are other payment options available. You can choose from quarterly direct billing, annual direct billing or automatic monthly check withdrawal.

If you would like to change your payment method, please contact the program administrator at 1-800-732-8350.

Beneficiary Selection
You may name anyone you wish as your beneficiary. You may change the beneficiary by contacting the Insurance Administrator in writing and advising them of the change.

You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

Continuing Insurance After the 20-Year Term Ends
Premiums are designed to remain level for the first 20 years of coverage*. At the end of the 20-year period, if you still meet the requirements of eligibility, you may apply for re-entry. A written application and proof of good health satisfactory to ReliaStar Life is required.

Or you can be automatically transferred to group annual renewable term life coverage with attained age rates, without proof of good health, and subject to all terms and eligibility requirements of the group policy. The initial premium rate will be based on your current age at the time of transfer.

*The initial premium will not change for the first twenty years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

Effective Date
Your insurance will become effective on the first day of the month on or after the later of the following dates:

- ReliaStar Life approves your proof of good health;
- Your premium is received;
- You become eligible for insurance; or
- You apply for insurance, if proof of good health is not required.

When Coverage Ends
Your insurance stops on the earliest of the following dates:

- The last day of the month during which you are no longer eligible for insurance under the Group Policy
- If you are not totally disabled, the date the Group Policy terminates.
- If you are totally disabled, the date ReliaStar Life stops waiving premiums under the Waiver of Life Insurance Premium Disability Benefit.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.

Exclusions
You're covered 365 days a year, wherever you are. The only exclusion is suicide within the first two years of the date your insurance or increase in insurance starts. The AD&D and Accelerated Life Benefits are subject to additional exclusions.

OTHER IMPORTANT INFORMATION

Accelerated Life Benefit
The Accelerated Life Benefit option is available to help terminally ill insureds during a difficult, and often financially challenging, time. Under this provision, you may request one advance payment equal to 50% of your in force life insurance, or $50,000, whichever is less, to be paid while you are still alive. The amount of insurance payable after the your death will be reduced by this payment. Premium contributions will not be reduced.

This money can be used to help cover high prescription drug costs … medical bills … outstanding debts … to help pay for experimental treatments … the cost of modifications to your home … or for a family vacation -the choice is yours.

To qualify, you must provide ReliaStar Life with a doctor's statement which gives the diagnosis of your medical condition and states you have a life expectancy of no more than six months. You must also have at least $20,000 of life insurance coverage. For additional details and limitations, please see the Certificate of Insurance.

Receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.

Accidental Death & Dismemberment Insurance Option
Group Accidental Death & Dismemberment (AD&D) Insurance can be elected up to the same level of life insurance being applied for. In addition, people are seriously injured by accidents and sustain loss of limb or eyesight. For these reasons, the MNCPA Group Accidental Death & Dismemberment (AD&D) Insurance is an important addition to your benefit plan.

Waiver of Life Insurance Premium Disability Benefit
You pay no premiums if you become totally disabled as defined in the certificate. Your insurance will continue at no cost to you if you become continuously totally disabled for at least six consecutive months and if your disability occurs before age 60. This coverage will remain in effect until age 65 at no cost as long as you remain disabled.

Employee Coverage Available
As an MNCPA member, you may also offer your employees (under age 50) 20-Year Level Term Life Insurance through ReliaStar Life. Employees may apply for $100,000 to $250,000 of coverage (in increments of $5,000).

In order for an employee to be covered, the employee must be eligible for the insurance, be actively at work, and be able to give ReliaStar Life acceptable proof of good health.

Employees that are approved for coverage will receive the Accelerated Life Benefit, Accidental Death & Dismemberment Insurance option and the waiver of Life Insurance premium disability benefit. Please see the Certificate for details.

Monthly Level Premium Rates per $1,000
Volume Band: $100,000 through $499,999

Age	Male Tobacco	Male Preferred	Male Super Preferred	Female Tobacco	Female Preferred	Female Super Preferred
18-25	0.145	0.070	0.053	0.105	0.053	0.042
26	0.145	0.070	0.053	0.105	0.053	0.042
27	0.152	0.073	0.053	0.113	0.055	0.043
28	0.161	0.076	0.057	0.123	0.057	0.044
29	0.172	0.080	0.060	0.133	0.059	0.045
30	0.189	0.088	0.067	0.148	0.065	0.049
31	0.203	0.092	0.069	0.160	0.068	0.051
32	0.219	0.097	0.072	0.172	0.072	0.054
33	0.237	0.102	0.075	0.187	0.076	0.056
34	0.258	0.107	0.078	0.202	0.080	0.059
35	0.280	0.113	0.081	0.218	0.084	0.061
36	0.305	0.122	0.087	0.235	0.091	0.065
37	0.332	0.132	0.093	0.254	0.098	0.070
38	0.361	0.143	0.100	0.274	0.105	0.074
39	0.394	0.154	0.107	0.295	0.113	0.079
40	0.429	0.167	0.115	0.317	0.121	0.084
41	0.467	0.180	0.124	0.341	0.129	0.089
42	0.509	0.195	0.133	0.365	0.136	0.094
43	0.553	0.210	0.143	0.391	0.144	0.099
44	0.602	0.227	0.154	0.419	0.153	0.104
45	0.662	0.251	0.172	0.458	0.168	0.115
46	0.716	0.274	0.186	0.488	0.180	0.123
47	0.773	0.299	0.203	0.520	0.194	0.132
48	0.836	0.327	0.220	0.555	0.209	0.141
49	0.905	0.358	0.240	0.592	0.226	0.152
50	0.982	0.394	0.263	0.631	0.245	0.164

Rates shown are as of January 1, 2024.

Premiums are based on the applicant's age at date of issue and on attained age at renewal dates. The initial premium will not change for the first twenty years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

The classes of rates are “Super Preferred,” “Preferred” and “Tobacco.” Only non tobacco-users may qualify for the “Super Preferred” and “Preferred” rates. (Note: Smokers may only qualify for the “Tobacco” rates.) Upon approval of your Application by the insurer, you will be notified of the rate classification for each approved person.

Acceptance into this Plan is subject to medical evidence of insurability as determined by ReliaStar Life. Depending on your age, amount of coverage you request and your answers on the Application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/tests requested by the insurer will be conducted at your convenience at no expense to you.

NOTE: If you choose the Accidental Death & Dismemberment option you will receive the same level of coverage as your 20-Year Level Term Life Insurance. The Accidental Death & Dismemberment rate is $0.04 per $1,000 of coverage per month, regardless or your age, gender and smoking status.

Child(ren) premiums: $2.30 monthly covers all dependent children, regardless of how many are insured for $10,000 each (2,500 for those age 14 days to 6 months).

If you are between the ages of 18 and 60 you may be eligible to apply for the MNCPA Group 10-Year Level Term Life Insurance. For more information including eligibility, rates, benefit provisions, exclusions, limitations and termination provisions, please contact the MNCPA Insurance Administrator at 1-800-732-8350.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

Monthly Level Premium Rates per $1,000
Volume Band: $500,000 through $1,000,000

Age	Male Tobacco	Male Preferred	Male Super Preferred	Female Tobacco	Female Preferred	Female Super Preferred
18-25	0.136	0.063	0.044	0.097	0.045	0.032
26	0.136	0.063	0.044	0.097	0.045	0.032
27	0.143	0.065	0.045	0.105	0.048	0.034
28	0.152	0.068	0.047	0.114	0.050	0.035
29	0.163	0.071	0.049	0.124	0.053	0.037
30	0.177	0.076	0.053	0.136	0.056	0.039
31	0.192	0.079	0.055	0.148	0.060	0.042
32	0.208	0.083	0.057	0.161	0.064	0.044
33	0.226	0.086	0.059	0.175	0.068	0.047
34	0.246	0.091	0.062	0.190	0.073	0.049
35	0.269	0.095	0.064	0.206	0.077	0.052
36	0.293	0.102	0.069	0.224	0.083	0.056
37	0.320	0.110	0.074	0.242	0.090	0.061
38	0.350	0.118	0.079	0.262	0.098	0.065
39	0.382	0.124	0.083	0.283	0.106	0.070
40	0.417	0.133	0.088	0.306	0.114	0.075
41	0.456	0.146	0.097	0.329	0.121	0.080
42	0.497	0.161	0.106	0.354	0.129	0.085
43	0.542	0.176	0.116	0.380	0.137	0.090
44	0.590	0.194	0.127	0.408	0.146	0.095
45	0.645	0.214	0.141	0.440	0.157	0.103
46	0.699	0.235	0.154	0.471	0.169	0.111
47	0.756	0.257	0.169	0.503	0.183	0.119
48	0.818	0.282	0.184	0.537	0.198	0.129
49	0.888	0.310	0.202	0.574	0.215	0.139
50	0.964	0.341	0.222	0.613	0.233	0.151

Rates shown are as of January 1, 2024.

Premiums are based on the applicant's age at date of issue and on attained age at renewal dates. The initial premium will not change for the first twenty years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

The classes of rates are “Super Preferred,” “Preferred” and “Tobacco.” Only non-tobacco users may qualify for the “Super Preferred” and “Preferred” rates. (Note: Smokers may only qualify for the “Tobacco” rates.) Upon approval of your Application by the insurer, you will be notified of the rate classification for each approved person.

Acceptance into this Plan is subject to medical evidence of insurability as determined by ReliaStar Life. Depending on your age, amount of coverage you request and your answers on the Application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/tests requested by the insurer will be conducted at your convenience at no expense to you.

NOTE: If you choose the Accidental Death & Dismemberment option you will receive the same level of coverage as your 20-Year Level Term Life Insurance. The Accidental Death & Dismemberment rate is $0.04 per $1,000 of coverage per month, regardless or your age, gender and smoking status.

Child(ren) premiums: $2.30 monthly covers all dependent children, regardless of how many are insured for $10,000 each (2,500 for those age 14 days to 6 months).

If you are between the ages of 18 and 60 you may be eligible to apply for the MNCPA Group 10-Year Level Term Life Insurance. For more information including eligibility, rates, benefit provisions, exclusions, limitations and termination provisions, please contact the MNCPA Insurance Administrator at 1-800-732-8350.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

About This Plan Information

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. The complete terms and conditions of coverage are contained in Group Policy 64269-0, which is issued to the Minnesota Society of Certified Public Accountants.
Policy Form LP08GP

This is a paid endorsement. MNCPA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

How to Apply

1. Complete, date and sign the Application included in the package. Be sure to indicate the coverage amount of your choice.

2. Do not send any money until ReliaStar Life Insurance Company has approved your Application and notifies you of the premium contribution due, based on the information you have provided.

3. Mail your completed Application to:

   MNCPA Group Insurance Program
   P.O. Box 14533
   Des Moines, IA 50306

Administered by:

Association Member Benefits Advisors, LLC (AMBA)
P.O. Box 14533
Des Moines, IA 50306

Call: 1-800-732-8350
Email: customerservice.service@getamba.com
Web: www.mncpa-insurance.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

Group Term Life Insurance Underwritten by:
ReliaStar Life Insurance Company
Minneapolis, MN

LI1037P-43237

THIS PAGE IS INTENTIONALLY LEFT BLANK.