Group Term Life Application

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ***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 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
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: ________________________________

PLEASE COMPLETE AND SIGN BACK OF APPLICATION ➡

2. SELECT YOUR COVERAGE

Member Amount

☐ $_____ *in $5,000 increments*
(Minimum: $5,000 Maximum: $500,000)

Spouse of Member Amount

☐ $_____ *in $5,000 increments*
(Minimum: $5,000 Maximum: $500,000)

Employee of Member Amount

☐ $_____ *in $5,000 increments*
(Minimum: $5,000 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: __________

	Member/ Employee	Spouse
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

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

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 #

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

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.

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

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's/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 Term Life Insurance Plan

FOR MINNESOTA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS MEMBERS

Up to $500,000 in life insurance benefits available

Term Life Benefits Provide Valuable Protection

The CPA Select Term Life Plan provides valuable benefits for your loved ones with up to $500,000 in coverage that may help with the financial needs they may face.

Here's What This Plan Provides

You and your spouse/domestic partner may apply for term life benefits from $5,000 to $500,000 (in $5,000 increments). A spouse/domestic partner is eligible for the same amount of coverage as the member. In addition, your eligible children can be covered for up to $10,000 in benefits.

Who May Apply

All MNCPA members and their spouses/domestic partners who are under age 60,actively performing the normal duties of their occupation, or activities of a person of like age and sex, can apply for coverage.

In addition, children from 6 months to 19 years of age (23 if a full-time student) may be eligible for up to $10,000 of coverage. Children 14 days to 6 months may be eligible for up to $2,500 of coverage.

Your full-time employees working at least 30 hours a week can apply for up to $250,000 in coverage.

MONTHLY PREMIUMS

Benefit Amount With Special Volume Discounts for $100,000 in coverage or more

Age	$50,000	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000	$500,000
Under 30	3.08	5.89	8.84	11.79	14.73	17.68	20.62	23.57	26.51	29.46
30-34	4.45	8.45	12.68	16.90	21.13	25.35	29.58	33.80	38.03	42.25
35-39	5.54	10.49	15.74	20.98	26.23	31.47	36.72	41.96	47.21	52.45
40-44	9.12	17.19	25.79	34.38	42.98	51.57	60.17	68.76	77.36	85.95
45-49	13.44	25.58	38.37	51.16	63.95	76.74	89.53	102.32	115.11	127.90
50-54	21.20	40.20	60.30	80.40	100.50	120.60	140.70	160.80	180.90	201.00
55-59	31.28	59.43	89.15	118.86	148.58	178.29	208.01	237.72	267.44	297.15
60-64*	47.92	91.04	136.56	182.08	227.60	273.12	318.64	364.16	409.68	455.20

**Only those under age 60 are eligible to apply. Rates are for renewal only for those up to age 64.*

Maximum employee benefit is $250,000. Rates increase as you enter a new age category and are subject to change, but will not be changed unless they are changed for all insureds in your classification. Member and spouse/domestic partner benefits reduce 25% of the original amount or to $37,500, whichever is less at age 65; spouse/domestic partner coverage terminates at age 70. Employees will receive 65% of their coverage from age 65 to 69, 50% of their coverage from age 70 to 74 and 30% of their coverage from age 75 on. Coverage terminates when the employee is no longer actively employed by the Member.

Contact the Administrator for rates over 64.

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).

Note: If you choose the Accidental Death & Dismemberment (AD&D) option you will receive the same level of coverage as your Term Life Insurance. The AD&D rate is $0.035 per $1,000 of coverage monthly.

Rates shown are guaranteed until June 30, 2024.

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.

IMPORTANT PLAN FEATURES

Accelerated Life Benefit Option Lets You Benefit From Your Own Plan

You may use the proceeds received from this benefit for any purpose. This benefit can be of value when a terminal illness creates a need for funds to help pay for medical expenses or nursing care. For example, if an insured member is diagnosed as terminally ill, subject to policy provisions, he/she can receive 50% of his/her insurance amount or $50,000, whichever is less. You must have at least $20,000 in Life Insurance coverage in force to qualify for this benefit and provide ReliaStar Life a doctor's statement which states that you have no more than 6 months to live because of the nature and severity of your medical condition. 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 Option

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

Volume Discounts

When you apply for $100,000 or more of coverage, you automatically qualify to receive volume premium discounts. That means even greater cost savings!

Premiums Waived if You Become Totally Disabled

If an insured member, spouse/domestic partner or employee becomes totally disabled (as defined by the certificate) prior to age 60, and remains continuously totally disabled for at least six consecutive months, ReliaStar Life will waive the Life Insurance premium. Coverage will remain in effect for members and spouses/domestic partners until age 65 and until the date of retirement for employees - at no cost - as long as he/she remains totally disabled.

Pays for Death From Any Cause

For life insurance, this Plan pays for death from any cause except suicide within two years of the effective date of coverage or increase in coverage. In that event, the insurance company will refund all premiums paid. The AD&D and Accelerated Life Benefit coverages are subject to additional exclusions.

Conversion

You may convert this Plan to an individual whole life policy when coverage terminates without proof of good health.

Money-Back Guarantee

Your satisfaction is guaranteed. When you receive your Certificate of Insurance, read it carefully. If you're not completely satisfied with the terms of your new insurance Plan, simply return your Certificate, without a claim having been submitted or paid, within 30 days and your premium will be promptly refunded. No questions asked! Your insurance will then be invalidated.

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

Complete, date and sign the enclosed Application. Mail the Application to the Group Insurance Administrator:

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

SEND NO MONEY NOW!
You will be billed when your application is approved.

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

ATL1037P-MNCPA

Copyright 2024 AMBA. All rights reserved.