FOR OFFICE USE ONLY
Name/Dept./Loc.
Acct. #/Pay Mode
Initial Premium

City of Tampa
GL-36012-1
Florida

CHILDREN'S PROOF OF GOOD HEALTH FORM

Portable Term Life

INSTRUCTIONS: Either eligible insured parent may apply for this coverage, but **not** both. To be eligible, the parent must already have Portable Term life insurance with ReliaStar Life Insurance Company (ReliaStar Life). Complete both sides of the form. *Print clearly in dark ink and return as instructed.*

Name of Insured Parent *(last, first, middle)*	Parent's Date of Birth		Parent's Social Security #
Street Address	City	State	Zip
Secondary Addressee Name and Address *(to be notified in case of lapse in coverage)*			
Check: ❒ Yes, I already have Portable Term life insurance with ReliaStar Life and now wish to add children's coverage.			

The beneficiary will be the insured parent to whose policy the children's coverage is added.

AMOUNT OF CHILDREN'S COVERAGE REQUESTED

Check one box: ❒ $10,000 ❒ $5,000
Coverage is limited to 10% of amount elected for children 14 days to 6 months of age.

NAMES OF CHILDREN TO BE COVERED

List the name(s), birth date(s), and student status of all eligible children, stepchildren and legally adopted children. If you need more space, attach a separate sheet signed and dated.

Last Name	First Name	Middle Initial	Date of Birth	Full-Time Student Status (yes or no)

PROVIDE US WITH THIS INFORMATION

		YES	NO
a.	Is any child living away from home? *If yes, state which child(ren) and their address(es):* _____	❒	❒
b.	Has insurance applied for on any child ever been declined, postponed or modified*? If yes, state which child, the reason and the date*._____	❒	❒
c.	Is each child named above now in good health and free from injury, disease or disorder? *If no, explain on back of form.*	❒	❒
d.	Has any child had or been advised to have any surgical operation? *If yes, explain below.*	❒	❒
e.	Has any child ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for the antibodies to the HIV virus? *If yes, explain on back of form.*	❒	❒
f.	Has any child ever had or been treated for nervous, brain or lung disorders, disorder of the immune system, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury or other disease or disorder. *If yes, explain on back of form.*	❒	❒
g.	Will this proposed insurance replace any life insurance or annuities your children now have in force? *If yes, give details.* _____	❒	❒

Please complete and sign the back side of the form.

Underwritten by ReliaStar Life Insurance Company

Please give full details below. Attach additional sheets if needed

Name of Child	Nature of Illness, Injury or Operation	Date(s) of Treatment	Remaining Effects	Name and Address of Physicians and Hospitals

PAYROLL DEDUCTION AUTHORIZATION *(to be signed by employee)*

I authorize my employer to deduct from my wages the premium for the requested children's coverage.

Employee's Name	Employee's Social Security #	Employee's I. D. Number
Employee's Signature		Date Signed

READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I've provided on this form is complete and correct.
- **Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life.
- I understand coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment:

For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc.(MIB), employer or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life), or its authorized representative (including 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 or any non-medical information as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the 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 and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 24 months from the date shown below.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Insured Parent's Signature:	Date Signed:

_____ _____ _____

Agent's Signature | Agent's Name (printed or typed) | Florida License I.D. Number

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, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

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, 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, Inc.

We or our reinsurers may make brief reports to 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 (TTY 866 346-3642). 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.