RESET FORM

Life Insurance Evidence of Insurability Form

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

- Personnel, payroll, or benefits office to complete Section 1; employee completes Sections 2 – 6. Type or print clearly in ink.
- **Also complete the *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form*** if you're enrolling within 60 days of initial eligibility.
- For help completing the form, please contact your personnel, payroll, or benefits office.
- Make and keep a copy of both sides of this form for your records.
- Return completed form to **ReliaStar Life Insurance Company, P.O. Box 20, Route 7812, Minneapolis, MN 55440-0020.**
- To check the status of your underwriting after sending this form to ReliaStar Life, contact ReliaStar Life at 1-800-537-5024, option 4.

SECTION 1: AGENCY/POLICYHOLDER INFORMATION *Personnel, payroll, or benefits office completes this section.*

Employing agency	**Agency/subagency code**	**Employee's hire date**
Policyholder name **Washington State Health Care Authority**	**Policyholder number** **123731**	

SECTION 2: EMPLOYEE INFORMATION *Employee completes this section.*

Social security number	Name (last, first, middle initial)	Date of birth (mm/dd/yyyy)	Employee I.D. number
Street address (include city, state, ZIP Code)			❑ Female ❑ Male
Mailing address (include city, state, ZIP Code)—if different from above		Work phone number	Home phone number

SECTION 3: SPOUSE OR QUALIFIED/WASHINGTON STATE-REGISTERED DOMESTIC PARTNER INFORMATION *Employee completes this section.*

Social security number	Name (last, first, middle initial)	Date of birth (mm/dd/yyyy)	❑ Female ❑ Male

SECTION 4: COVERAGE REQUESTED *Employee completes this section.*

Type of request *(check all that apply)*:

❑ Initial enrollment (for new groups joining PEBB)
❑ New hire (newly eligible)
❑ Request to cover spouse/partner*
❑ Late entrant (person requesting coverage after initial eligibility)
❑ Request to increase coverage amounts after initial eligibility
❑ Other _____

**within 60 days of marriage or qualified/Washington State-registered domestic partnership, or within 31 days of spouse's/partner's loss of other PEBB life insurance*

*Select the coverage you are requesting, then enter the dollar amount of **current coverage** (including any guaranteed amount, if applicable), the dollar amount of the **total coverage desired**, and the difference between these two dollar amounts in the **amount to be underwritten**. Your personnel, payroll, or benefits office can help you determine the current coverage amount(s) for you and/or your spouse/partner's life insurance.*

	Current Coverage	**Total Coverage Desired**	**Amount to be Underwritten**
❑ Employee Supplemental Life Insurance	$	$	$
❑ Spouse/Partner Basic Life Insurance	$	$ **2,500**	$
❑ Spouse/Partner Supplemental Life Insurance	$	$	$

SECTION 5: EVIDENCE OF INSURABILITY INFORMATION

For employee coverage: *Complete when applying for or increasing Employee Supplemental Life Insurance after 60 days of being newly eligible, or when applying for more than $250,000 (under age 60) or $100,000 (age 60 or over) within 60 days of being newly eligible.*

For spouse or qualified/Washington State-registered domestic partner coverage: *Complete when applying for or increasing Supplemental Spouse/Partner Life Insurance after 60 days of being newly eligible, or for more than $50,000 Supplemental Spouse/Partner Life Insurance within 60 days of being newly eligible.*

	Employee	Spouse/Partner		Employee	Spouse/Partner
1. What is your height and weight? *Fill in here.* ➔	HT _____ WT _____	HT_____ WT _____	5. Do you anticipate being under a doctor's care for any condition within the next six months?	❑ Yes ❑ No	❑ Yes ❑ No
2. Have you ever had or been treated for lung disorder, asthma, high blood pressure, heart trouble, nervous disorder, liver or stomach disorder, kidney or urinary disorder, diabetes, arthritis, cancer, high triglycerides/cholesterol, alcohol/chemical abuse, depression, or any physical/mental impairment?	❑ Yes ❑ No	❑ Yes ❑ No	6. Have you had, been told you had, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), AIDS-related conditions, or tested positive for the antibodies for the AIDS virus?	❑ Yes ❑ No	❑ Yes ❑ No
3. In the last three years, have you had or been treated for ulcer, back/neck trouble, eye or ear impairment, ear infections, any disorder or disease of the breast, any disorder or disease of the reproductive system or prostrate, carpel tunnel syndrome, knee disorder, infertility, or memory/concentration problems?	❑ Yes ❑ No	❑ Yes ❑ No	7. Have you been previously declined by ReliaStar or any other life insurance company?	❑ Yes ❑ No	❑ Yes ❑ No
4. Have you consulted a physician, received surgical or medical care, or taken prescribed medication for any condition during the past 12 months (including current treatment)?	❑ Yes ❑ No	❑ Yes ❑ No	8. Are you currently pregnant?	❑ Yes ❑ No If yes, expected due date: _____	❑ Yes ❑ No If yes, expected due date: _____

If you answered "yes" to any of the questions above, use this area to provide details. Use a separate sheet if needed.

Question No.	Family Member	Condition/Injury/Illness/ Type of Treatment	Date of Treatment	Health Care Provider's Name, Address, & Phone Number
	❑ Employee ❑ Spouse or qualified/Washington State-registered domestic partner			
	❑ Employee ❑ Spouse or qualified/Washington State-registered domestic partner			

SECTION 6: AUTHORIZATION/SIGNATURE *Please read and sign below.*

For underwriting and claims purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative 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 me or to my spouse or qualified/Washington State-registered domestic partner who is to be covered.

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 this Federal Regulation 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, Inc. 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 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Insurance Information Practices Notice and Notice Regarding MIB, Inc.

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.

Date	Employee's signature *(required)*	Employee's printed name
Date	Spouse or domestic partner's signature *(required if applying)*	Spouse or partner's printed name

ReliaStar Life Insurance Company
Insurance Information Practices Notice and Notice Regarding MIB, Inc.

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

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.