PIERCE INSURANCE
Employee Benefits Specialists

NC Department of Health and Human Services

Congratulations on your new position with North Carolina DHHS!

You have the opportunity to enroll in Voluntary Benefits during the **first 90 days** of your employment.

Learn about your opportunity to participate in Voya's Term Life with Guaranteed Issue below.

SCAN ME

Voya Term Life

- As a new hire you have 90 days to take advantage of ***Guaranteed Issue****. Meaning you can enroll without answering health questions.
- This coverage is designed to protect your income during your working years.
- **Portability** for when you separate from employment or retire.
- Employee coverage is not required to enroll spouse.
- Opportunity to convert policy into permanent life insurance during Open Enrollment periods or when you separate employment.
- Higher coverage amounts are available with health questions.

For detailed plan information, rates, and enrollment call Pierce Insurance at **800-421-3142** or visit pierceins.com/department-of-health-and-human-services

*During your first 90 days of employment, you are eligible to apply for up to $150,000 on yourself and/or up to $20,000 on your spouse. You must speak with a representative of Pierce Insurance Agency for complete details. Late entrants may enroll at any time with health questions.

Group Term Life Insurance

It's your life. Your future.
Protect it with life insurance.

ReliaStar Life Insurance Company,
a member of the Voya® family of companies

PLAN | INVEST | PROTECT

VOYA® FINANCIAL

The unexpected does happen

You don't think about it. And it certainly can't happen to you. But then the unexpected happens. The chief breadwinner is gone and the family is left without the financial resources they may need for the future. And while many U.S. households have life insurance, the average amount of coverage is often inadequate to meet family needs or pay off debt.

You work hard to protect and provide for your family, yet you also need to financially protect their future.

How life insurance can help you:

- **Protect your family:** Your family depends on your income. Life insurance helps replace that income when your family needs it most.
- **Protect your home:** For most families, their home is their largest asset. Life insurance can enable your family to remain in the home, pay the mortgage and avoid relocation.
- **Protect your children's education:** Covering the soaring cost of education becomes even more difficult when there is a loss of income. Life insurance can help provide for your children's future.
- **Settle expenses:** Life insurance can also help cover financial expenses, such as medical bills and funeral costs, as well as unplanned expenses and unforeseen financial crises.

Your employer can select the following customized options for your benefit plan:

Availability and benefit provisions vary by state. For more information or to see if your plan includes any of these options, please consult your employer.

- **Supplemental:** This gives you the opportunity to buy additional coverage for added protection. Your employer may provide you with a basic amount of life insurance at no cost to you. Through this program, you may increase the amount of your Group Term Life Insurance coverage.
- **Portability:** This gives you the opportunity to take coverage with you when you leave your employer. You may "port" your supplemental coverage with you if you change jobs or retire – something very important in today's ever-changing work environment. (Benefit and availability may vary by state.)
- **Accidental Death and Dismemberment (AD&D):** This provides extra coverage in case of a covered accident. Additional benefits are paid to you for a covered accident resulting in the loss of limbs, sight or life.
- **Spouse/child coverage:** Coverage is also available for your dependents. (Spouse coverage over certain levels must be approved through Underwriting.)

Why enroll through your employer?

At Voya Employee Benefits, we offer these features with our Group Life Insurance products:

- **Easy enrollment:** Enrollment is simple with our easy-to-follow enrollment forms. For the cost of supplemental coverage, refer to your employer's rate information.
- **Convenient payroll deductions:** Premiums are automatically deducted from your paycheck.
- **Waiver of Premium:** If you become totally disabled (as defined by the policy) and cannot work, you don't have to pay life insurance premiums for as long as you remain disabled, up to this benefit's termination.
- **Exceptional customer service:** Knowledgeable service representatives and courteous claims professionals are available to answer your questions and address your needs.
- **Accelerated Benefit***:** You may collect a portion of your death benefit (typically 50 percent) while you are living, if you are diagnosed with a terminal illness with a life expectancy of under 12 months*. All remaining benefits will be paid to the beneficiary upon death.
- **Beneficiary Support Services:** Life insurance proceeds are given to your beneficiaries through an interest-bearing draw account. In addition, we offer access to financial professionals and personal guidance to help beneficiaries achieve their goals.**

* May vary by state.

** Proceeds of $5,000 or more are generally paid into a Voya Personal Transition Account. Voya Personal Transition Accounts are not available in all states.

***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.

How much coverage do I need?

Every person is different, as are their life insurance needs. The sample worksheet provides an example to help you start thinking about how much coverage is right for you. If you are interested in a more comprehensive worksheet, visit Voya.com and click on "Life Insurance Needs Calculator" under the "Tools" section.

Sample worksheet

Final expenses	$10,000	$_____
Debts	$8,000	$_____
Housing costs (Remaining mortgage, rent expense, utilities, etc.)	$232,000	$_____
Education fund	$0	$_____
Other	$0	$_____
Total	**$250,000**	**$_____**

Bottom line

Life insurance provides basic protection for your loved ones if something happens to you. The loss of your income could create immediate financial hardship and lifestyle changes for your family. Life insurance helps assure your family can maintain financial security and meet financial obligations. Taking advantage of the life insurance coverage provided by your employer can play an important role in your financial strategy.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage is provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form ICC LP14GP or LP00GP (may vary by state).

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VOYA® FINANCIAL

RESET FORM

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life or Disability Income coverage or **any** increases in Life or Disability Income coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name **North Carolina Department of Health and Human Service** Effective Date of Coverage or Change _____
Group/Plan Number **30920-6** Account Number/Location _____
Class/Occupation _____
Date of Hire _____ Annual Salary $_____ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired

This change is due to *(Check all that apply.)*:
☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other _____
[1] *A late entrant is an individual who is first enrolling after the initial available opportunity.*

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Employee ID Number _____ Work Phone (_____)_____ Home Phone (_____)_____
Address _____ City _____ State _____ ZIP _____
Has the employee used tobacco products of any kind in the last 12 months? ☐ Yes ☐ No

EMPLOYEE LIFE / AD&D INSURANCE

Supplemental Life / Supplemental AD&D Insurance

Employee Guaranteed Issue (GI) Limit = $150,000 for employees under age 60, ($50,000 for age 60-64 and $30,000 age 65 and over). When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability.

During the annual enrollment period:

- If you have current supplemental life coverage, you may elect to increase your coverage by $20,000 or two plan increment, whichever is less without providing evidence of insurability during the current enrollment period. Evidence of Insurability will be required for any amount exceeding the $150,000 GI Limit.
- If you are a Late Entrant, you must provide evidence of insurability for any elected coverage.
    - Total supplemental life coverage up to $500,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Employee Supplemental Life Insurance Election

☐ I currently have supplemental life coverage of: $_____.
☐ I am applying for additional supplemental life coverage of: $_____. *($10,000 increments)*
☐ Total supplemental life coverage (current plus additional): $ 0.00 .
☐ Waive coverage.

EMPLOYEE Supplemental AD&D INSURANCE

Supplemental AD&D Insurance Election

☐ Amount equal to supplemental life insurance coverage up to a maximum amount of $250,000.
☐ Waive coverage.

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BENEFICIARY INFORMATION

(Designate your beneficiary (ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐M ☐F				☐Primary ☐Contingent
	Address			**Phone ( )**			
2			☐M ☐F				☐Primary ☐Contingent
	Address			**Phone ( )**			
3			☐M ☐F				☐Primary ☐Contingent
	Address			**Phone ( )**			

SPOUSE LIFE / AD&D INSURANCE

(The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employer for more information.)

Supplemental Life / Supplemental AD&D Insurance

You may elect Spouse coverage even if you do not elect Supplemental Life coverage on yourself.

Spouse Guaranteed Issue (GI) Limit = $20,000 of coverage on spouse under age 60, $10,000 of coverage if spouse age is 60-69, coverage is not available to spouses age 70 and older. When you are first eligible for spouse life coverage, you may elect up to the GI Limit without evidence of insurability.

During the annual enrollment period:

- Spouses may elect to increase their current coverage amount by $10,000 or a one plan increment, whichever is less without providing evidence of insurability during current enrollment period.
- If you are a Late Entrant, you must provide evidence of insurability for any elected coverage.

Total supplemental life coverage up to $500,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Supplemental Life Insurance Election

☐ I currently have spouse supplemental life coverage of: $_____.
☐ I am applying for additional spouse supplemental life coverage of: $_____. *($10,000 increments)*
☐ Total supplemental life coverage (current plus additional): $ 0.00 .
☐ Waive coverage.

Spouse AD&D Life Insurance Election

☐ Amount equal to spouse life insurance coverage up to $250,000. *($10,000 increments)*
☐ Waive coverage.

Note: *The employee is the beneficiary for any Spouse insurance coverage.*

SPOUSE INFORMATION

Enter information below.

	Spouse Name *(First, MI, Last)*	DOB	Gender	SSN
			☐M ☐F	
	Address			**Phone ( )**

1833493-0923

CHILDREN LIFE INSURANCE

When you are initially eligible for Children coverage, you can elect it without evidence of insurability. All other applications for new Child coverage more than 90 days after the date you become eligible for Child(ren) coverage Evidence of Insurability will be required the insurance company.

During the annual enrollment Period:

- If you have current child life coverage, you may elect to increase your current coverage amount by $4,000 or two plan increments whichever is less, without evidence of insurability.
- If you are a Late Entrant, you must provide evidence of insurability for any elected coverage.

An available choice of child(ren) life coverage of up to $10,000 is available for your children ages 6 months but less than 19 years, for full-time student dependents age 19 but less than 25 years. Children age 14 days but less than 6 months of age are covered for $1,000.

Note: *The employee is the beneficiary for any Spouse and Children insurance coverage. Supplemental AD&D is not available for Child coverage.*

Children Life Insurance Election

☐ I currently have child life coverage of: $_____.
☐ I am applying for additional child life coverage of: $_____. *($2,000 increments)*
☐ Total child life coverage (current plus additional): $ 0.00 .
☐ Waive coverage.

CHILDREN INFORMATION

Enter information below. If additional space is required please attach a separate document.

	Child Name *(First, MI, Last)*	DOB	Gender	SSN
1			☐M ☐F	
	Address			**Phone**
2			☐M ☐F	
	Address			**Phone**
3			☐M ☐F	
	Address			**Phone**

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee Signature _____ Date _____

1833493-0923

FRAUD WARNINGS

Arkansas, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia: 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and 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.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

1833493-0923

How much does my life insurance cost?

The cost is calculated based on the age of the employee at the start of the plan's current policy year.
The rates shown are guaranteed until 12/31/2023.

Employee and Spouse Supplemental Life Insurance

Age	Monthly Cost of Coverage Per:				
	$10,000	$20,000	$40,000	$80,000	$100,000
Under 30	$0.72	$1.44	$2.88	$5.76	$7.20
30-34	$1.08	$2.16	$4.32	$8.64	$10.80
35-39	$1.44	$2.88	$5.76	$11.52	$14.40
40-44	$2.34	$4.68	$9.36	$18.72	$23.40
45-49	$3.51	$7.02	$14.04	$28.08	$35.10
50-54	$5.58	$11.16	$22.32	$44.64	$55.80
55-59	$10.17	$20.34	$40.68	$81.36	$101.70
60-64	$15.57	$31.14	$62.28	$124.56	$155.70
65-69	$30.06	$60.12	$120.24	$240.48	$300.60
70 +	$48.69	$97.38	$194.76	$389.52	$486.90

Dependent Children Life Insurance

Coverage Levels	Monthly Cost
$ 2,000 each child	$0.41
$ 4,000 each child	$0.83
$ 6,000 each child	$1.24
$ 8,000 each child	$1.66
$10,000 each child	$2.07

The amount of coverage elected is for all eligible children for one low payroll deduction.

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

Supplemental AD&D Coverage	Monthly Cost of Coverage Per:				
	$10,000	$20,000	$40,000	$80,000	$100,000
Employee AD&D	$0.26	$0.52	$1.04	$2.08	$2.60
Dependent Spouse AD&D	$0.26	$0.52	$1.04	$2.08	$2.60

Exclusions and limitations
ReliaStar Life pays the death benefit for all causes of death. However, if you commit suicide, while sane or insane, within 2 years of the date your insurance starts, ReliaStar Life will refund the amount of premiums paid for your Life Insurance under the Group Policy instead of paying a death benefit.

Accidental Death and Dismemberment Insurance has exclusions that are described in the certificate of insurance or rider. Accidental Death Insurance has exclusions that are described in the certificate of insurance or rider.

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 insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form ICC LP14GP or LP00GP (may vary by state).

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES **Unit No.**_____

MISCELLANEOUS DEDUCTION CHANGE FORM

Full Name (print)_____

Personnel No._____

Please do not include your social security number on this form.

Payroll Date_____

Personnel Action Involved? (Yes or No. If yes, what type?) _____

PAYROLL USE		DESCRIPTION	CHANGE FROM	CHANGE TO
2454	*	NC Prepaid Legal Services		
2455	*	Prepaid Legal Services Inc		
2456		NCAE Dues		
2450		NC Combined Campaign		
2458		NC Public Service Workers Union		
2459		Ultimate Advisor Legal Plan/ARAG		
2463	*	Capital American Life Ins Co.		
2466	*	Cincinati Life Ins Co.		
2469	*	Protective Life Insurance Co.		
2470	*	American Family Life Assu.		
2471	*	National Foundation Life Ins		
2474	*	State Farm Ins Co.		
2475	*	Aegon SID		
2477	*	American Heritage Insurance Co.		
401R		Roth 401(K) Plan - Prudential		
2480	*	Victory Life Insurance Co.		
2481	*	Alta Health and Life Ins.		
2482	*	Loyal American Life Ins Co.		
2483	*	Central United Life Ins Co.		
2485	*	Liberty National Life Ins. Co.		
2490	*	Aetna Ins Co.		
2491	*	Northwest National Life Ins. Co.		
2492		Bankers Sec Life Incs. Co. (VOYA)		
2493	*	Assurant Employee Benefit		
2494	*	Occidental Life of NC		
2495	*	United Teachers Associates, Inc.		
2499	*	General American Life Ins.		
2501	*	Ameritas Life Insurance Corp. (Dental)		
2502	*	BCBS (Dental)		
2507	*	Jefferson- Pilot Life Insurance Co.		
2509		Professional Insurance Corp. (GE)		
2511	*	Investers Consolidated Ins. Co.		
2513		Kanawha		

This form can not be used to enroll, cancel or change any of the following miscellaneous deductions:
NC Flex accounts, SEANC Dues, SEANC Ins., 529 College Savings Plan, credit union, parking, 401-K, Colonial or deferred compensation.

****This form can only be used if the employee does not have a break in coverage while on LWOP.**

I hereby authorize the following payroll deduction (s) or deduction change (s).

Signature_____Date_____

***INACTIVE - NO NEW ENROLLMENTS, TRANSFERS or INCREASES due to additional coverage added.(This form can be used to reinstate misc. deductions from LWOP, cancel coverage or do blanket rate increases)**

It is only necessary to fill out the following pages if you are applying for benefits over the guarantee issue amount.

RESET FORM

EVIDENCE OF INSURABILITY (NC)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya family of companies
PO Box 20, Mail Stop 4-S, Minneapolis, MN 55440
Phone: 612.342.7262 Fax: 612.467.8721

VOYA FINANCIAL™

Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number 309206 Account Number _____ Employer Name NCDHHS NC Dept Health Human Services
Location _____ Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female
SSN _____ Personal Email Address _____ Birth Date _____
Address _____ City _____ State _____ ZIP _____
Home Phone (_____) _____ Cell Phone (_____) _____
Hire Date _____ Salary $_____ Occupation _____
Primary Health Practitioner _____ Practitioner Phone (_____) _____
Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS *(Complete this table based only on the coverage you have through this plan.)*

Are you completing this form due to a Family Status Change *(Marriage, Divorce, Birth, Adoption, etc.)*? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
☐ Employee Supplemental Life	$	$	$	$
☐ Spouse Supplemental Life	$	$	$	$
☐ Children Supplemental Life (per child)	$	$	$	$

C. SPOUSE INFORMATION

Spouse Name *(First, MI, Last)* _____ Gender: ☐ Male ☐ Female
SSN _____ Personal Email Address _____ Birth Date _____
Home Phone (_____) _____ Cell Phone (_____) _____
☐ Same Primary Health Practitioner as Employee *(See information above.)*
Primary Health Practitioner _____ Practitioner Phone (_____) _____
Practitioner Address _____ City _____ State _____ ZIP _____

D. CHILD INFORMATION *(Availability of Child coverage is dependent on plan rules and may also be dependent on approved employee coverage. If more than 3 children, list information on additional sheet.)*

Name *(First, MI, Last)*	Birth Date	Gender	Relationship
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Dependent Children Health Questions *(Answer these questions only if applying for dependent child(ren) coverage.)*

1. Within the past 5 years, have any dependent children been treated for or diagnosed with a mental or nervous disorder (excluding ADHD), diabetes, heart disorder, cancer, asthma (requiring hospitalization within the last 2 years), or chemical abuse? . . . . . ☐ Yes ☐ No
2. Do any dependent children have cerebral palsy, cystic fibrosis, muscular dystrophy, developmental disorder (including Autism and Down's Syndrome), or complications associated with premature birth? . . . . . ☐ Yes ☐ No

For each "Yes" answer, provide name(s) of child(ren) and details. _____

0000000000

Employee Name _____ SSN ***(Last 4 digits only.)*** _____

E. EMPLOYEE AND SPOUSE HEALTH QUESTIONS *(Must be answered for coverage that is not Guaranteed Issue.)*

Employee (EE) Yes	Employee (EE) No	Spouse (SP) Yes	Spouse (SP) No	
☐	☐	☐	☐	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having a positive Human Immunodeficiency Virus (HIV) infection (symptomatic and asymptomatic) and Acquired Immune Deficiency Syndrome (AIDS)?
☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/ angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP. --->				3. **Employee:** Height _____ ft. _____ in. Weight _____ lbs. **Spouse:** Height _____ ft. _____ in. Weight _____ lbs.
				4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
☐	☐	☐	☐	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
☐	☐	☐	☐	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	e. Polycystic kidney disease or kidney failure?
				5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory disorder?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disorder?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
☐	☐	☐	☐	e. Stomach disorder?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
☐	☐	☐	☐	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
☐	☐	☐	☐	8. Have you ever received medical treatment or counseling, other than membership in a substance or chemical dependency support group, for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
☐	☐	☐	☐	9. In the past 2 years have you experienced any health symptom(s) that impact your ability to work or conduct activities of daily living for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	

Employee Name _____ SSN ***(Last 4 digits only.)*** _____

F. AUTHORIZATION AND ACKNOWLEDGMENT *(Please read and sign below)*

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency, 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). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described 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 permission 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 specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further 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 a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.
I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Submit your EOI form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: 1-612-467-8721

Or

Mail to: ReliaStar Life Insurance Company, PO Box 20, Mail Stop 4-S, Minneapolis, MN 55440

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CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya family of companies

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.