RESET FORM

Life Insurance Application

VOYA FINANCIAL

Product Name _____

Type of Enrollment / Change: *(check all that apply)*

☐ New Application ☐ Increase ☐ Reinstatement ☐ Other _____

☐ *ReliaStar Life Insurance Company*
Home Office: Minneapolis, Minnesota 55440
☐ *ReliaStar Life Insurance Company of New York*
Home Office: Woodbury, NY 11797

Administrative Office:
PO Box 122, Minneapolis, Minnesota 55440-0122

Home Office Use Only - Policy Number(s) and Activation Date(s):

Employee	Spouse	Dependent #1	Dependent #2	Dependent #3

Section A. Employer and Billing Information

1. Employer: _____

2. Group Benefit Plan # _____ **3.** Pay Mode: _____

4. Employee ID #: _____ **5.** Dept. #: _____ **6.** Loc. #: _____

Section B. Employee/Owner Information

1. Employee Name: _____

2. Address: _____

City, State, ZIP: _____

3. Phone #: (_____) _____ **4.** Date of Hire: _____ **5.** Annual Salary: $ _____

6. Are you actively at work? ☐ Yes ☐ No **7.** Social Security #: _____ – _____ – _____

Section C. Proposed Insured Information

	Employee	**Spouse**	**Dependent Child #1**	**Dependent Child #2**	**Dependent Child #3**
			(Complete only if applying for an individual dependent policy.)		
Name					
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Birthdate					
Age as of Proposed Effective Date					

	Employee	**Spouse**	**Dependent Child #1**	**Dependent Child #2**	**Dependent Child #3**
Has the proposed insured used tobacco in any form in the last 24 months? *(Respond if 18 years of age or older.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section D. Coverage Information

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Death Benefit Option *(Check one only if Universal Life)*	☐ Option A ☐ Option B	☐ Option A ☐ Option B	☐ Option A ☐ Option B	☐ Option A ☐ Option B	☐ Option A ☐ Option B
Face Amount	$	$	$	$	$
Base Weekly Premium	$	$	$	$	$
Excess Weekly Premium *(Applies to Universal Life only)*	$	$	$	$	$

Riders*/Options

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Waiver	☐ Yes				
CTR Number of Units *(Complete Section H)*					
ADB Face Amount	$	$			
FAIR $ per Week	☐ $1.00 ☐ $2.00	☐ $1.00			
ABR **or** LTC **or** ADBR *(Choose Only One)*	☐ ABR ☐ LTC ☐ ADBR	☐ ABR ☐ LTC ☐ ADBR	☐ ABR	☐ ABR	☐ ABR
Level Term to Age 65 *(% and Face Amount)*	_____% $	_____% $			
Other:					
Other:					

Total Weekly Premium	**$**	**$**	**$**	**$**	**$**

*Whole Life Riders: Accelerated Benefit Rider (ABR); Accidental Death Benefit Rider (ADB); Accelerated Death Benefit Rider (ADBR); Children's Term Insurance Rider (CTR); Long Term Care Rider (LTC); Level Term to Age 65 Rider (T65); Waiver of Premium Rider (Waiver).

*Universal Life Riders: Accelerated Benefit Rider (ABR); Accidental Death Benefit Rider (ADB); Children's Term Insurance Rider (CTR); Face Amount Increase Rider (FAIR); Waiver of Monthly Deduction Rider (Waiver).

Section E. Replacement Information

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
1. Do you have any existing policies or contracts? (If Yes, complete state Notice Regarding Replacement, if required.) Current Carrier:	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____
2. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If Yes, complete state-required replacement form and provide details.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? (If Yes, complete state-required replacement form and provide details.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Producer: a) Does the applicant have any existing life insurance policies or annuity contracts? (If Yes, complete state Notice Regarding Replacement.) b) To the best of your knowledge, does this insurance replace any existing insurance or annuities?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No

Section F. Beneficiary Information *(If no beneficiary is designated, the proceeds will be paid to the owner, if living, otherwise to the owner's estate.)*

	Employee	Spouse	Dependent Child #1	Dependent Child #2	Dependent Child #3
Beneficiary #1 Name	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent
Percentage	%	%	%	%	%
Relationship					
Beneficiary #2 Name	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent	☐ Primary ☐ Contingent
Percentage	%	%	%	%	%
Relationship					
Additional Beneficiary Information					

SECTION G: Acknowledgement and Certification / Agreement and Signature

PROPOSED OWNER'S STATEMENT: All statements and answers are complete and true to the best of my knowledge and belief. It is agreed that all such statements and answers shall be made a part of any insurance policy/rider(s) issued.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud, against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD WARNING STATEMENT

Arkansas, Louisiana, Maine, Ohio, Oklahoma, 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.

Florida: 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.

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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

I UNDERSTAND THAT THE INSURANCE WILL BE EFFECTIVE ON THE POLICY/RIDER(S) EFFECTIVE DATE. I, the owner, acknowledge that I saw a Quotation of Potential Policy Values only, when I applied for my new policy. I know that a complete illustration conforming to the policy as issued will be provided no later than the policy delivery if required by law.

Producer's Statement:

I certify that a Quotation of Potential Policy Values only was used in connection with the sale of the policy applied for, and that I have explained to the applicant that a complete illustration conforming to the policy as issued will be produced and delivered with the policy.

I further certify that I have explained that any nonguaranteed elements of the policy are subject to change. I have made no statements that are inconsistent with the illustration, which will be delivered with the policy if required by law.

PAYROLL DEDUCTION AUTHORIZATION: I authorize my Employer to deduct from my paycheck each pay period such sums certified to my Employer by ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York (ReliaStar Life), or it's affiliate, or their Administrator, as necessary to pay the premium due for my insurance policy(ies). I assign these sums to ReliaStar Life or their Administrator. I authorize my Employer to make future changes in payroll deduction resulting from changes in my ReliaStar Life insurance coverage.

<table>
<tr><td>Proposed Effective Date (Month, Day, Year):</td><td colspan="2">Amendments, Corrections and Notations made by Home Office:</td></tr>
<tr><td>Signed at (City & State):</td><td>On (Month, Day, Year):</td><td>Signature of Proposed Owner (Employee):</td></tr>
<tr><td colspan="2">Producer's Name (please print):</td><td>Signature of Proposed Insured Spouse:</td></tr>
<tr><td colspan="2">Producer's License Number:</td><td>Signature of Parent or Guardian:</td></tr>
<tr><td colspan="2">Signature of Producer:</td><td>Signature(s) of Proposed Insured Children age 15 and Older:</td></tr>
<tr><td colspan="3">Remarks or Special Requests:</td></tr>
</table>

POLICY INFORMATION DISCLOSURE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Administrative Office: PO Box 122, Minneapolis, MN 55440-0122

ATTENTION ALL POLICY OWNERS

The Company wants to make sure it can identify and contact your named beneficiaries upon the death of the insured, therefore the Company requests that you provide the following information for the **Policy Owner, Insured and every individual identified as a Beneficiary on your policy**.

- Name (First, MI, Last)
- Birth Date
- Address
- Social Security Number
- Telephone Number

If any of the above noted information is not available to you at that time your Application is completed, you may provide the information below and return this signed form to the Company.

POLICY INFORMATION *(Complete this section and return it signed to the Company, if you wish to provide any of the above mentioned missing information about your policy.)*

IMPORTANT NOTE: This form cannot be used to change your current Beneficiary designation. If you wish to change a Beneficiary Designation, contact the Company for the appropriate form.

Policy Number *(if known)* _____ Insured Name _____

Policy Owner Name _____

Name *(First, MI, Last)*	Role as listed on the Application	Birth Date	Address	SSN	Telephone Number
	☐ Insured ☐ Owner ☐ Beneficiary				
	☐ Insured ☐ Owner ☐ Beneficiary				
	☐ Insured ☐ Owner ☐ Beneficiary				
	☐ Insured ☐ Owner ☐ Beneficiary				
	☐ Insured ☐ Owner ☐ Beneficiary				
	☐ Insured ☐ Owner ☐ Beneficiary				

CERTIFICATION STATEMENT

I certify that all information provided is true, correct and complete to the best of my knowledge and belief.

Policy Owner Signature _____ Date _____

HOME OFFICE USE ONLY

Group Name *(if known)* _____ Group Number *(if known)* _____

Order #171127 12/11/2014