

Group Term Life Insurance Application Form

FOR MEMBERS OF THE CIVIL SERVICE EMPLOYEES BENEFIT ASSOCIATION

Underwritten by ReliaStar Life Insurance Company



Use this application only if you are a new federal government employee applying for coverage within the first 45 days of your employment. If completing this application in paper format during the designated eligibility period, complete and return to: WrightUSA Insurance Plan Administrator, PO Box 588, Concord, NC 28026-0588. Phone 877-966-3690; Fax 704-786-1526. You may also apply at www.wrightusa.com.

MEMBER INFORMATION

Policy No. 67182-7

Member Name (<i>last, first, middle initial</i>)		Date of Birth (<i>month, day, year</i>)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Applicant Reference Number (applicable only if enrolled on-line)		E-mail Address	
Address			
City		State	ZIP
Daytime Telephone		Other Telephone	
Are you a Federal Government Employee working full-time (17.5 or more hours per week?) <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of Hire (<i>m,d,yr</i>)
Agency Name	Occupation	GS/SES Level	Annual Salary
How did you hear about WrightUSA? <input type="checkbox"/> New Employee Orientation (NEA) <input type="checkbox"/> Agency Benefits Office <input type="checkbox"/> Mail Advertisement <input type="checkbox"/> Open Season Event <input type="checkbox"/> Coworker <input type="checkbox"/> Other (please specify) : _____			

INSURANCE REQUESTED -- Check box(es) to apply for insurance benefits as specified:

MEMBER COVERAGE:

- I apply for Group Term Life and AD&D Insurance on a Guaranteed Issue basis in an amount equal to 1x my annual salary (as listed above), rounded to the next highest \$1,000 (if not already an even \$1,000) or \$25,000, whichever is larger; maximum \$300,000: YES NO
- I wish to apply for additional coverage, subject to approval by ReliaStar Life, in an amount not to exceed total coverage of \$300,000. Please indicate additional coverage applied for: \$ _____
(*Note: Member must answer health questions on next page to apply for additional coverage*)
- Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? If yes, please explain : _____

BENEFICIARY INFORMATION

List one or more beneficiaries below. List the percent for each. The total must equal 100 percent. (*The beneficiary for dependent spouse and/or child coverage (if elected) will be the member.*)

Name	Address	Relationship	Percent

CHILD COVERAGE:

- I apply for Dependent Child(ren) life insurance in the amount of \$10,000 (*Eligible child is unmarried dependent child under age 19, or under age 25 if a full-time student.*) YES NO

SPOUSE COVERAGE:

If applying for Dependent Spouse coverage (spouse must be under age 65 at time of application) complete the following:

Spouse Name (<i>last, first, middle initial</i>)	Date of Birth (<i>month, day, year</i>)	<input type="checkbox"/> Male <input type="checkbox"/> Female
--	---	--

- I apply for Dependent Spouse group term life insurance in the following amount (minimum \$25,000; maximum is the lesser of the member's total amount of coverage or \$100,000): \$ _____
(*Note: Spouse must answer health questions below to apply for coverage*)

(*See next page for health questions, if applicable, and signature area; application is invalid if not signed and dated.*)

MEMBER – ANSWER THE FOLLOWING HEALTH QUESTIONS ONLY IF APPLYING FOR MORE THAN THE GUARANTEED ISSUE AMOUNT OF COVERAGE:

- a) Provide your height and weight: Height: _____ft____” Weight: _____lbs
- b) Are any medical, surgical or diagnostic procedures recommended or contemplated for the Proposed Insured? Yes No
- c) During the past 5 years have you consulted a doctor or health practitioner, taken medication or had treatment for any of the following: cancer, stroke, diabetes, organ transplant, disease or disorder of the heart, brain, liver, intestine, kidney, blood, lung (excluding asthma requiring oral steroid use), or circulatory (excluding controlled high blood pressure). Yes No
- d) Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus? Yes No
- e) In the past 5 years have you sought help for or been treated for major or manic depression, suicide attempt, use of alcohol, drugs or narcotics, or been convicted of driving under the influence of drugs and/or alcohol? Yes No

SPOUSE – ANSWER THE FOLLOWING HEALTH QUESTIONS ONLY IF APPLYING FOR COVERAGE:

- a) During the past 5 years have you consulted a doctor or health practitioner, taken medication or had treatment for any of the following: heart trouble, stroke, diabetes or cancer? Yes No
- b) Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus? Yes No
- c) In the past 5 years have you sought help for or been treated for major or manic depression, suicide attempt, use of alcohol, drugs or narcotics, or been convicted of driving under the influence of drugs and/or alcohol? Yes No

COMPLETE THE FOLLOWING PAYMENT OPTION SECTION: (Choose only one)

- Option 1: ELECTRONIC FUNDS TRANSFER (EFT):** Monthly Quarterly
 I request and authorize WrightUSA Insurance Plan Administrator to make withdrawals against the account specified on the attached voided check statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X _____
 Signature(s) as required on checks issued against this account Date

- Option 2: QUARTERLY DIRECT BILL** (Quarterly billing dates will begin after coverage is approved and initial premium has been received.)

READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I've 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. Insurance requiring premium payment by the insured will become effective upon approval by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the first day of the month after approval by ReliaStar Life Insurance Company.

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.

Member signature (required)	Date
Spouse signature (only if applying for coverage)	Date