Group Term Life Application for 10-Year Level Term Rate

EMPORIA STATE UNIVERSITY
ALUMNI ASSOCIATION

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ***ESUAA Group Insurance Program, P.O. Box 10374, Des Moines, IA 50306-8812, or call 1-888-560-2586, or email customerservice.service@mercer.com.***

Emporia State University Alumni Association **Policy No. 66816-8**

1. TELL US ABOUT YOURSELF

Alum's Information ***(complete this section only if applying for Alum coverage on this application):***

Name (Last, First, M.I.)			☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Spouse's Information ***(complete this section only if applying for Spouse coverage on this application):***

Name (Last, First, M.I.)	Name of Alum		☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Dependent Child(ren)'s Information ***(complete this section only if applying for Dependent Child(ren) on this application).***

Number of eligible children:_____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Name _____ DOB _____ SSN _____

Address	City	State	Zip	Home/Cell Phone #

	Alum	Spouse
a.) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No
Date of last use (month/year):	____/____	____/____
b.) Are you currently working less than 30 hours per week at your regular occupation and place of business?	☐ Yes ☐ No	☐ Yes ☐ No
c.) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please explain:_____

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

2. SELECT YOUR COVERAGE

10-Year Level Term
Alum Amount

- $1,000,000
- $500,000
- $250,000
- $_____ *in $10,000 increments*
  (Minimum: $200,000 Maximum: $1,000,000)

10-Year Level Term
Spouse Amount

- $1,000,000
- $500,000
- $250,000
- $_____ *in $10,000 increments*
  (Minimum: $200,000 Maximum: $1,000,000)

Please select if you wish to include additional options with your coverage *(If AD&D is elected, benefit will match life amount to a maximum of $500,000):*

- Alum Accidental Death & Dismemberment
- Spouse Accidental Death & Dismemberment
- Dependent Child(ren) Coverage*
  - $10,000
  - $5,000

*If both Alum and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

3. PROVIDE YOUR HEALTH INFORMATION

Alum: **Height**_____**ft.** _____**in. Weight**_____**lbs.** Spouse: **Height**_____**ft.** _____**in. Weight**_____**lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Alum: _____ Spouse: _____

_____ _____

	Alum	Spouse
1.) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?	Yes No	Yes No
2.) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack), sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?	Yes No	Yes No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?	Yes No	Yes No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?	Yes No	Yes No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?	Yes No	Yes No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?	Yes No	Yes No
3.) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?	Yes No	Yes No
4.) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?	Yes No	Yes No
5.) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?	Yes No	Yes No
6.) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?	Yes No	Yes No
a. Alum's driver's license number and state of issue:_____		
b. Spouse's driver's license number and state of issue:_____		
7.) Have you ever applied for insurance that was declined, postponed or modified in any way?	Yes No	Yes No
8.) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?	Yes No	Yes No

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

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

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				
	☐ Alum ☐ Spouse				

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Alum Coverage ***(complete this section only if applying for Alum coverage on this application)***

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

Beneficiary for Spouse Coverage ***(complete this section only if applying for Spouse coverage on this application)***

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

Name (Last, First, M.I.)				
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship	Percent
Address	City	State	Zip	Home/Cell Phone #

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

(Choose only one. Option selected is applicable to all coverages approved through this application):

Option 1: **AUTOMATIC CHECK WITHDRAWAL REQUEST:** Monthly Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: _____ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

Option 2: **DIRECT BILL:** Quarterly Semi-Annual Annual

Billing dates will begin after coverage is approved and initial premium has been received.

6. 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 and the first premium is paid in my lifetime.**
- **I understand my coverage begins on the "effective date" assigned by the Company.**

Authorization and Acknowledgment - Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or 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, pharmacy prescriptions or prescription records or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these 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 its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, 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. 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.

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, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Alum's Signature (always required)	Date	Spouse's Signature (if applying)	Date

Owner of Alum Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.)	Date of Birth (MM/DD/YYYY)	Social Security Number		
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature			Date	

Owner of Spouse Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (Last, First, M.I.)	Date of Birth (MM/DD/YYYY)	Social Security Number		
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature			Date	

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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, LLC., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." 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, LLC, 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, LLC.

We or our reinsurers may make brief reports to MIB, LLC (hereafter "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. 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.

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Group 10-Year Level Term Life Insurance Plan

EMPORIA STATE UNIVERSITY
ALUMNI ASSOCIATION

As an alum, you can:

- Customize your family's financial safety net with benefits ranging from $200,000 up to $1 million.
- Keep costs down with **competitive group rates.**
- Take a look at **no risk** with your "30-Day Free Look."
- Apply for spouse and/or child coverage.
- Your loved ones can collect double your life benefit if you die in a covered accident.
- Collect a portion of your benefits in the event of a terminal illness, as defined in the Certificate.

Once your coverage is approved by the insurer and put in force, there will be **no benefit reductions**. The plan is designed so that there will be **no rate increases** for 10 full years.*

With benefits ranging from $200,000 to $1 million (in increments of $10,000), you can help build a strong financial safety net for your family with the new Group 10-Year Level Term Life Insurance Plan. Plus, your spouse can apply for coverage up to an amount equal to yours.

Your new Group 10-Year Level Term Life Insurance Plan was designed to address you and your family's financial responsibilities. The rates you have when approved for coverage are PROJECTED not to increase for a full 10 years,* ***and*** your benefits as issued will not decrease during your initial level term.

*The initial premium rate will not change for the first 10 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

Level Life Benefits for You and Your Spouse

As an alum age 60 or under, you can apply for benefits for yourself. Your spouse age 60 or under, if not legally divorced or separated from you, can also apply for coverage. The amount of insurance for a Spouse can not exceed the Member's amount.

This is important coverage when you consider that many families rely on two incomes these days. All of your unmarried, dependent children ages 14 days to under 21 years (25 if full-time student) also qualify for coverage.

Collect a Portion of Your Benefits if Terminally Ill

This important plan option gives you the ability to collect part of your Group 10-Year Level Term Life benefits before your death. If your doctor diagnoses you with a terminal illness from which no recovery is expected, that results in a life expectancy of 6 months or less, you are entitled to collect up to 50 percent of your benefits (or $50,000, whichever is less) to use however you wish. You must have at least $10,000 in Life Insurance coverage in force to qualify for this benefit. 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.

Collect Double Benefits for Accidental Death & Dismemberment

You can elect Group Accidental Death & Dismemberment Insurance (AD&D) up to the same level of death benefit for which you are applying. (AD&D insurance, if elected, will match the life benefit amount to a maximum of $500,000.) In addition, if you are seriously injured in a covered accident and sustain loss of limb, eyesight or other injuries, a partial benefit may be payable.

(Please note: The rates will increase by $6.00 (quarterly) or $12.00 (semiannually) per $50,000 of AD&D coverage if you select this option.)

When Your Coverage Starts

Your insurance will become effective, subject to timely payment of premium, on the first of the month following the later of the date:

- ReliaStar Life approves your proof of good health;
- You become eligible for insurance; or
- You apply for insurance, if proof of good health is not required.

No Risk With Your 30-Day Free Look

There's no risk for you when you apply for this important benefit today. Upon approval of your Group 10-Year Level Term Life Insurance Coverage by the insurer, you'll be mailed a Certificate of Insurance. Look it over for 30 days. If you're not completely satisfied, just return your Certificate within 30 days marked "Cancel" and your coverage file will be closed, provided no claims have been submitted or paid. No hassles and no questions asked!

You Choose Your Beneficiary

You may name anyone you wish as the beneficiary of this plan, and you may change the beneficiary by contacting the Insurance Administrator in writing and advising them of the change. You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

Covered 365 Days a Year

No matter where you are, this plan covers you. The only exclusion is suicide, while sane or insane, within two years of the date your insurance or increase in insurance starts. The Accelerated Life and AD&D benefits are subject to additional exclusions.

If suicide occurs within the 2 year period, ReliaStar Life will refund only the amount of premiums paid for your insurance or increase in insurance under the Group Policy. ReliaStar Life will not pay a death benefit.

When Your Coverage Ends

As long as you remain an active alum, pay your premium when due, and the Group Policy remains in force, you can keep your coverage. For alum or spouses who are under age 70 at the end of a level term period, coverage can be continued under a five-year age bracketed rate plan if unable to re-qualify for a new 10-year level term rate period. Upon attainment of age 70, your amount of insurance will decrease to the lesser of 50% of the original face amount or $50,000, and terminate at age 75.

Your insurance stops on the earliest of the following dates:

- The last day of the quarter during which you are no longer eligible for insurance under the Group Policy.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.
- The date the Group Policy terminates.
- The premium due date on or after your 75th birthday.
- For Accelerated Life Benefit, the date your life insurance stops.
- For AD&D Insurance, the date your life insurance stops.

PLEASE KEEP FOR YOUR RECORDS

All alum and their spouses must complete an application form for any new coverage, to increase coverage (including dependent child coverage), or to begin an initial or subsequent 10-year Level Term Rate Period when proof of good health is required. Some applicants may be required to have a medical exam in order to apply for coverage. For more information on medical requirements, please contact your Plan Administrator. If there is an increase in the amount of your insurance, the increase will take effect on the first day of the month on or next following the date of the increase.

If you are in a Level Term Rate Period, premiums for the increased amount of insurance will be based on your attained age on the effective date of the increase. Your Group 10-Year Level Term Life Plan will start on the first day of the month after your application has been approved by the insurer and your first premium has been paid.

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 coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Complete details can be found in Group Policy 66816-8, Policy Form #LP08GP.

This program may not be available to residents of all states. This is a paid endorsement. Alumni Group Insurance Trust receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

Quarterly 10 Year Level Premium Rates per $1,000

Quarterly Rates*

Your rate is the rate for your age at the time coverage is issued.

Tobacco User, Non-Tobacco Preferred and Non-Tobacco Super-Preferred Class

Note: Level Premium Rates apply to both Member & Spouse.

*The initial premium rate will not change for the first 10 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

Rates as of 04/01/2022

	Volume Band: $200,000 through $499,999						Volume Band: $500,000 through $1,000,000					
Issue Age	Male Tobacco	Male Non-Tobacco Preferred	Male Non-Tobacco Super Preferred	Female Tobacco	Female Non-Tobacco Preferred	Female Non-Tobacco Super Preferred	Male Tobacco	Male Non-Tobacco Preferred	Male Non-Tobacco Super Preferred	Female Tobacco	Female Non-Tobacco Preferred	Female Non-Tobacco Super Preferred
18-26	0.362	0.156	0.128	0.240	0.138	0.114	0.336	0.150	0.124	0.214	0.132	0.110
27	0.366	0.160	0.128	0.252	0.142	0.114	0.342	0.152	0.124	0.226	0.136	0.110
28	0.376	0.160	0.128	0.266	0.142	0.114	0.352	0.152	0.124	0.240	0.136	0.110
29	0.392	0.160	0.132	0.282	0.142	0.114	0.366	0.152	0.124	0.256	0.136	0.110
30	0.410	0.160	0.132	0.302	0.142	0.114	0.384	0.152	0.124	0.276	0.136	0.110
31	0.432	0.164	0.132	0.322	0.142	0.114	0.408	0.156	0.124	0.298	0.136	0.110
32	0.460	0.164	0.132	0.348	0.142	0.114	0.434	0.156	0.124	0.322	0.136	0.110
33	0.492	0.164	0.136	0.376	0.142	0.114	0.466	0.156	0.128	0.350	0.136	0.110
34	0.526	0.166	0.136	0.406	0.142	0.114	0.500	0.160	0.128	0.382	0.136	0.110
35	0.566	0.166	0.136	0.440	0.142	0.118	0.542	0.160	0.128	0.416	0.136	0.114
36	0.610	0.166	0.136	0.480	0.146	0.118	0.586	0.160	0.128	0.454	0.138	0.114
37	0.658	0.170	0.136	0.520	0.150	0.122	0.634	0.164	0.128	0.494	0.142	0.118
38	0.714	0.170	0.146	0.564	0.164	0.132	0.688	0.164	0.138	0.538	0.156	0.124
39	0.774	0.180	0.158	0.608	0.174	0.146	0.748	0.174	0.142	0.582	0.166	0.138
40	0.840	0.188	0.164	0.654	0.188	0.152	0.814	0.180	0.156	0.628	0.180	0.146
41	0.916	0.226	0.176	0.700	0.204	0.166	0.890	0.216	0.170	0.674	0.198	0.160
42	0.998	0.250	0.198	0.748	0.222	0.180	0.972	0.240	0.190	0.722	0.212	0.174
43	1.086	0.268	0.216	0.798	0.246	0.198	1.060	0.258	0.208	0.772	0.236	0.190
44	1.176	0.298	0.236	0.848	0.268	0.216	1.150	0.288	0.226	0.824	0.258	0.208
45	1.294	0.324	0.268	0.928	0.288	0.232	1.254	0.310	0.258	0.888	0.278	0.222
46	1.386	0.354	0.284	0.980	0.306	0.250	1.348	0.340	0.274	0.940	0.292	0.240
47	1.478	0.400	0.312	1.032	0.334	0.268	1.440	0.382	0.298	0.992	0.320	0.258
48	1.578	0.434	0.338	1.088	0.354	0.284	1.538	0.418	0.324	1.048	0.340	0.274
49	1.690	0.476	0.368	1.148	0.372	0.302	1.650	0.458	0.354	1.108	0.358	0.292
50	1.814	0.528	0.404	1.212	0.404	0.320	1.774	0.508	0.386	1.172	0.386	0.306
51	1.936	0.580	0.444	1.272	0.432	0.348	1.896	0.556	0.428	1.232	0.414	0.334
52	2.066	0.632	0.494	1.334	0.462	0.378	2.026	0.608	0.472	1.294	0.444	0.364
53	2.206	0.698	0.546	1.400	0.494	0.406	2.168	0.664	0.524	1.360	0.472	0.390
54	2.358	0.758	0.606	1.472	0.532	0.444	2.320	0.726	0.580	1.434	0.512	0.428
55	2.516	0.834	0.668	1.548	0.570	0.480	2.478	0.800	0.640	1.510	0.546	0.458
56	2.670	0.912	0.734	1.628	0.616	0.512	2.632	0.876	0.706	1.590	0.592	0.490
57	2.830	0.984	0.800	1.712	0.658	0.542	2.794	0.946	0.768	1.674	0.630	0.522
58	3.022	1.082	0.880	1.804	0.712	0.584	2.984	1.040	0.846	1.766	0.686	0.560
59	3.266	1.186	0.966	1.906	0.772	0.618	3.228	1.138	0.928	1.870	0.740	0.594
60	3.558	1.312	1.072	2.012	0.824	0.672	3.522	1.260	1.030	1.976	0.792	0.644

Note: If you choose the Accidental Death and Dismemberment (AD&D) option, you will receive the same level of coverage as your 10-Year Level Life Insurance up to $500,000. The AD&D rate is $6.00 (quarterly) or $12.00 (semiannually) per $50,000 of AD&D coverage, regardless of your age, gender and smoking status.

Child Coverage: You can insure all your eligible children. Just one monthly premium of $1.50 covers all children for $1,000 (ages 14 days to 6 months) and $10,000 (ages 6 months to 21 years of age; unless they are full time students where they can be covered to 25 years of age). Child coverage of $500/$5,000 is also available for $.75 per month.

At time of application, a quarterly or semiannual billing option can be selected. (Quarterly premiums will be one-half of the semiannual premiums. Note that rates shown above may not be exact due to rounding and depending on the billing option selected.)

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

Premiums are based on the applicant's age at date of issue and on attained age at renewal dates.

The classes of rates are "Non-Tobacco Super-Preferred," "Non-Tobacco Preferred" and "Tobacco." "Non-tobacco" may qualify for the higher "Preferred" rates. (Note: Tobacco users may only qualify for the "Tobacco" rates.) Upon approval of your application, you will be notified of the rate classification for each approved person. You will be billed on a quarterly or semiannual basis. (Other billing options including annual or monthly Electronic Funds Transfer, can be selected after first billing.)

Acceptance into this plan is subject to medical evidence of insurability as determined by ReliaStar Life. Depending on your age, amount of coverage you request and your answers on the application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience at no expense to you.

How to Apply

1. Complete, date and sign the Application included in the package. Be sure to indicate the coverage amount of your choice.

2. Do not send any money until ReliaStar Life Insurance Company has approved your Application and notifies you of the premium payment due, based on the information you have provided.

3. Mail your completed Application to:
   Alumni Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

Administered by:

AMBA Administrators, Inc.

P.O. Box 10374
Des Moines, IA 50306-8812

Association Member Benefits Advisors, LLC.

AR Insurance License #100114462

CA Insurance License #0I96562

In CA d/b/a Association Member Benefits & Insurance Agency

QUESTIONS?
1-888-560-2586
www.esuaa.alumniplans.com

Group Term Life Insurance Underwritten By:
ReliaStar Life Insurance Company
Minneapolis, MN

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