ILLINOIS STATE BAR ASSOCIATION

Group Term Life Application

Please complete the entire application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ***ISBA Group Insurance Program, P.O. Box 10374, Des Moines, IA 50306-8812, or call 1-800-503-9230, or email customerservice.service@mercer.com.***

Illinois State Bar Association **Policy No. 67941-1**

1. TELL US ABOUT YOURSELF

Member's Information ***(complete this section only if applying for Member 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/Domestic Partner of Member's Information ***(complete this section only if applying for Spouse/Domestic Partner coverage on this application):***

Name (Last, First, M.I.)	Name of Member	❑ Spouse of Member ❑ Domestic Partner (DP) of Member	❑ 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 #

	Member	**Spouse/DP**
a.) Do you currently use or have you used tobacco or nicotine products in any form in the last 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
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:_____

2. SELECT YOUR COVERAGE

Member Amount

❑ $_____ *in $5,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Spouse/Domestic Partner Amount

❑ $_____ *in $5,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Please select if you wish to include additional options with your :

❑ $5,000 Dependent Child(ren) Coverage*

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

3. PROVIDE YOUR HEALTH INFORMATION

Member: **Height_____ft. _____in. Weight_____lbs.** Spouse/DP**: 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:

Member:_____ Spouse/DP:_____

_____ _____

	Member	Spouse/DP
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. Member'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

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
	❑ Member ❑ Spouse/DP				
	❑ Member ❑ Spouse/DP				
	❑ Member ❑ Spouse/DP				
	❑ Member ❑ Spouse/DP				
	❑ Member ❑ Spouse/DP				
	❑ Member ❑ Spouse/DP				

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 Member Coverage ***(complete this section only if applying for Member 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/Domestic Partner Coverage ***(complete this section only if applying for Spouse/Domestic Partner 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 #

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 have 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 ReliaStar Life Insurance 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 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.

Member's Signature (always required)	Date	Spouse/Domestic Partner's Signature (if applying)	Date

---

Owner of Member 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/Domestic Partner 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	

THIS PAGE IS INTENTIONALLY LEFT BLANK.

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, 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.

THIS PAGE IS INTENTIONALLY LEFT BLANK.

Domestic Partnership Declaration

Name of Applicant _____

Name of Domestic Partner _____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.

2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).

3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):

- ❑ Common ownership of a motor vehicle.
- ❑ Joint bank or credit accounts.
- ❑ Assignment of durable power of attorney in favor of one another.
- ❑ Common ownership of real estate or common leasehold interest in property.
- ❑ Joint ownership or holding of stocks, bonds or other investments.
- ❑ Execution of will naming each other as executor and/or beneficiary.
- ❑ Designation as beneficiary under the other's retirement or pension benefits account.

4. That the undersigned member and domestic partner (check one):

- ❑ have filed a domestic partner declaration with the (City/Council/Borough) of_____ and that such domestic partner declaration remains in effect (attach copy of declaration).
- ❑ do not reside in a jurisdiction that provides for the registration of domestic partnership declarations.

5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.

6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.

7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability that would prevent them from making this affidavit.

8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.

9. That the undersigned member and domestic partner are not related by blood in any degree that would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature_____ **Date**_____

Soc. Sec. No._____

Domestic Partner's Signature_____ **Date**_____

Soc. Sec. No._____

THIS PAGE IS INTENTIONALLY LEFT BLANK.

Group Term Life Insurance Plan

ILLINOIS STATE BAR ASSOCIATION

FOR ISBA MEMBERS AND THEIR FAMILIES

LIFE INSURANCE HELPS PROVIDE SECURITY FOR FAMILIES

The last thing you want your family to have to worry about, at a time when they have so much on their minds, is where they will turn for financial security. Group Term Life Insurance is an economical way to help make sure they are provided for.

WHO CAN APPLY FOR UP TO $500,000 OF COVERAGE?

All members in good standing and their spouses/domestic partners under age 60 may apply. In addition, unmarried, dependent children ages 6 months through 18 years (22 if a full-time student) are eligible for $5,000 of coverage. Children ages 14 days to 6 months may be insured for $1,000 each. You and your spouse/domestic partner, if applying, must be actively at work on the date insurance is to take effect. If not, such insurance will take effect on the day you resume normal duties of your occupation.

If dependent children are hospitalized on the date insurance is to take effect, the dependent coverage will be delayed until the day after hospital discharge.

KEY PLAN FEATURES

Continuation of Insurance Without Premium Payment During Disability

If you or your spouse/domestic partner become totally disabled, as defined by the certificate, before age 60 and the disability continues for at least six months with no interruption, your Group Term Life Insurance may continue without premium payment. Continuation of insurance will end on the earliest of: total disability ends, proof of total disability is not given by you when due, you are not examined by a doctor when required, or you attain age 70.

YOU SELECT 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.

ACCELERATED BENEFITS

If you and/or your spouse/domestic partner are diagnosed with a terminal illness (which is defined as a medical condition which is expected to result in the insured's death within 24 months and from which the person is not expected to recover), the Accelerated Benefits allows you to elect to receive 60% of your Life Insurance in force, not to exceed $250,000, prior to death.

The remaining benefit then becomes payable to your beneficiary after your death. Accelerated life benefits are not payable if the insured person has made an absolute assignment of his life insurance under the group policy, all or part of the insured person's life insurance under the group is to be paid to his child(ren) or former spouse as part of a court approved divorce agreement, is not received written consent by any irrevocable beneficiary, or if the terminal illness is a result of intentional self-inflicted injury or attempted suicide. 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.

Note: The minimum Accelerated Benefit is $10,000, which means you must have at least $10,000 of coverage in force. After age 70, coverage does not include the Accelerated Benefit.

There is no additional premium charged for the Accelerated Benefit.

CONVERSION RIGHTS

If your insurance ends for a reason other than nonpayment of premium, you may convert to an individual whole life insurance policy from ReliaStar Life Insurance Company during the conversion period without providing evidence of insurability. The amount of the new policy may be limited depending on the reason your insurance ends.

ECONOMICAL PREMIUMS

Receive Volume Discount Premium Rates when you apply for $250,000 or more of coverage. There are also lower rates for non-tobacco users.

SATISFACTION GUARANTEED

You may return your Certificate of Insurance within 30 days if you are not completely satisfied with the coverage this Plan provides. Any premiums paid will be fully refunded provided no claims have been submitted or paid.

EFFECTIVE DATE

Your insurance will become effective on the first day of the month on or after the later of the following dates:

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

WHEN COVERAGE ENDS

Your insurance stops on the earliest of the following dates:

- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.
- The Group Policy anniversary date on or after your 80th birthday.
- For Accelerated Life Benefit, date on or after your 70th birthday.

EXCLUSIONS

You're covered 365 days a year, wherever you are. The only exclusion for life insurance is suicide within the 2 years of the date your insurance or increase in insurance starts. The Accelerated Life Benefit is subject to additional exclusions.

HOW TO APPLY:

1. Complete, sign and date the enclosed application.

2. Remember to select your payment option. If you select Automatic Monthly Check Withdrawal, please include a blank voided check and a check for your first monthly premium. If you select Semi-Annual Direct Bill, just include a check for your first semi-annual premium.

3. Make checks payable to:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

GROUP ANNUAL TERM
MONTHLY RATES PER $10,000
Rates are guaranteed until March 31, 2021

	Less than $250,000 coverage				$250,000 coverage or More			
	Non-Tobacco		Tobacco		Non-Tobacco		Tobacco	
Age	Male	Female	Male	Female	Male	Female	Male	Female
Under 30	$0.65	$0.51	$0.75	$0.59	$0.58	$0.46	$0.67	$0.53
30-34	$0.75	$0.56	$0.87	$0.65	$0.68	$0.51	$0.78	$0.58
35-39	$1.04	$0.72	$1.20	$0.84	$0.93	$0.65	$1.08	$0.75
40-44	$1.62	$1.08	$1.87	$1.24	$1.46	$0.97	$1.68	$1.12
45-49	$2.63	$1.65	$3.03	$1.91	$2.37	$1.49	$2.73	$1.72
50-54	$4.09	$2.58	$4.72	$2.97	$3.68	$2.32	$4.25	$2.68
55-59	$6.33	$3.98	$7.31	$4.59	$5.70	$3.58	$6.58	$4.14
60-79	$6.82	$4.76	$7.87	$5.49	$6.14	$4.28	$7.08	$4.94

Receive Volume Discount Premium Rates when you apply for $250,000 or more of coverage.

Children's Coverage: $0.83 (per family, regardless of number of children) monthly for $5,000 benefit for children age 6 months through 18 years (22 if full-time student). $1,000 benefit for children age 14 days to 6 months.

Children's Coverage With Volume Discount: $0.75 (per family, regardless of number of children) monthly for $5,000 benefit with Volume Discount for children age 6 months through 18 years (22 if full-time student). $1,000 benefit for children age 14 days to 6 months.

***Renewal Only.** Coverage reduces by 50% on the policy anniversary date at or following age 65, 70, and 75. Coverage terminates at age 80. Children ages 14 days to 6 months may be insured for $1,000 each. All premiums are based on applicant's attained age at the date of issue and on the policy anniversary date. Premiums will increase as the applicant enters a new 5 year age bracket.

COMPUTING YOUR PREMIUM IF PAYING THROUGH AUTOMATIC MONTHLY CHECK WITHDRAWAL: Find the appropriate monthly rate above based on the amount of coverage you are applying for, your sex, age, and smoker/non-smoker status. Multiply that rate by the number of $10,000 units you are applying for. **EXAMPLE:** Let's say you are a 35-year-old male non-smoker and wish to apply for $200,000. Take $1.04 x 20 units ($200,00 divided by $10,000 unit) = $20.80. This is your monthly premium.

COMPUTING YOUR PREMIUM IF PAYING THROUGH SEMI-ANNUAL DIRECT BILL: Follow the same steps described above, then multiply the total monthly premium by 6. **EXAMPLE:** Take $20.80 (the total monthly premium figured above) x 6 = $124.80.

Policy Form LP00GP

Administered By:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
ISBA Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?
1-800-503-9230
www.isbainsuranceplans.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

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

ABOUT THIS PLAN INFORMATION

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. The complete terms and conditions of coverage are contained in Group Policy 67941-1, which is issued to the Illinois State Bar Association. Product provisions and availability may vary by state.
This is a Paid Endorsement. The ISBA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

Policy Form LP00GP

Group Policy #67941-1

LI1037P-50006

THIS PAGE IS INTENTIONALLY LEFT BLANK.