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 ***MSBA Group Insurance Program, P.O. Box 10374, Des Moines, IA 50306-8812, or call 1-800-501-5776, or email customerservice.service@mercer.com.***

Minnesota State Bar Association	**Policy No. 29063-7**

1. TELL US ABOUT YOURSELF

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

Name (Last, First, M.I.)	Name of Member	❑ Member ❑ Employee 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	

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/ Employee	**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:____

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

2. SELECT YOUR COVERAGE

Member Amount	**Spouse of Member Amount**	**Employee of Member Amount**
❑ $________ *in $5,000 increments*	❑ $________ *in $5,000 increments*	❑ $________ *in $5,000 increments*
(Minimum: $10,000 Maximum: $1,000,000)	*(Minimum: $10,000 Maximum: $1,000,000)*	*(Minimum: $10,000 Maximum: $250,000)*

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

- ❑ Dependent Child(ren) Coverage*
  - ❑ $25,000 ❑ $10,000
- ❑ Member/Employee Accidental Death & Dismemberment
- ❑ Spouse of Member Accidental Death & Dismemberment

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

3. PROVIDE YOUR HEALTH INFORMATION

Member/Employee: **Height_______ft. _______in. Weight______lbs.** Spouse/DP of Member: **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/Employee:____ Spouse/DP:____

____ ____

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services performed at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization (at the bottom of this application) for a definition of "Emergency Medical Personnel."

	Member/ Employee	**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/Employee's driver's license number and state of issue:________________________________

b. Spouse/DP'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
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ 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 Member/Employee Coverage ***(complete this section only if applying for Member/Employee 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 of Member Coverage ***(complete this section only if applying for Spouse/DP 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.

PLEASE COMPLETE AND SIGN BACK OF APPLICATION

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, or my authorized representative, have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid as long as I am continually insured with ReliaStar Life or 12 months, whichever is less. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

This authorization excludes the release of information about HIV (AIDS Virus) which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services, licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services, crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care, and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good Samaritan law.

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/Employee's Signature (Member signature required for Spouse/DP of Member application)	Date	Spouse/DP of Member's Signature (if applying)	Date

Owner of Member/Employee 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 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

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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, 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.

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Group Term Life Insurance Plan

FOR MSBA MEMBERS AND THEIR FAMILIES

VALUABLE BENEFITS

Up to $1,000,000 of Member and Spouse or Domestic Partner Coverage

You don't have to apply for coverage in order for your spouse or domestic partner to apply for life insurance.

Affordable Group Rates
The premium rates for the Group Term Life Plan are competitive. You may be surprised at how much insurance you can afford.

Premiums Can Be Waived if You Become Totally Disabled

Volume Discounts
The more you buy, the more you save. Discounts start at $200,000 of coverage; rates are discounted even more for coverage amounts of $500,000 or more.

Premiums Discounted for Non-Tobacco Users

Portable Coverage
The plan offers portable coverage that can follow you throughout your career. Make all the career changes you want and still maintain this valuable coverage.

Conversion to an Individual Whole Life Policy When Coverage Terminates if You Meet Conversion Requirements

Living Benefits Option (Accelerated Life Benefit)
Enables you to apply for a portion of your life insurance benefits if you become terminally ill, subject to certain policy restrictions and limitations. These benefits are paid directly to you, and you may spend them any way you wish.

COVERAGE OPTIONS UP TO $1,000,000

MSBA members and their spouses/domestic partners can obtain up to $1,000,000 of coverage in $10,000 increments. Eligible dependent children may be insured for $10,000 or $25,000. Children age 14 days but less than 6 months may be insured for $2,000 or $5,000.

BROAD ELIGIBILITY FOR YOU AND YOUR FAMILY

All MSBA members and their spouses or domestic partners who are under age 60 actively performing the normal duties of their occupation, or activities of a person of like age and sex, can apply for coverage. Unmarried, dependent children who are age 14 days to 19 years old (23 if full-time student) may also be covered. NOTE: You do not have to apply for coverage in order for your spouse or domestic partner to apply for this life insurance.

YOUR EMPLOYEES MAY BE ELIGIBLE, TOO

Employees of MSBA members working at least 30 hours a week are eligible to apply for up to $250,000 in $5,000 increments of this valuable term life insurance.

MONEY-SAVINGS FEATURES OF MSBA TERM LIFE

Group Purchasing Power Equals Savings

MSBA Group Term Life converts the mass purchasing power of your association into an insurance value for you and your family. And your premium won't be individually increased because your health condition changes. It will be increased only when you move into a higher age bracket or when rates for the entire age bracket are increased.

Volume Discounts
Coverages starting at $200,000 and again at $500,000 reflect a discount for volume purchases.

Discounts for Non-Tobacco Users
If you or your spouse or domestic partner have not smoked cigarettes or used tobacco products in any form during the past 12 months, you may take advantage of the lower rates available for non-tobacco users.

MSBA Group Term Life Insurance
Annual Rates per $1,000 of Coverage

Less than $200,000		
AGE	**Non-Tobacco**	**Tobacco**
<35	0.83	1.37
35-39	1.29	2.21
40-44	1.56	2.83
45-49	2.94	4.77
50-54	3.94	8.34
55-59	6.61	13.58
60*	8.44	15.79
61*	9.36	16.71
62*	10.74	17.35
63*	11.93	18.17
64*	14.31	20.19
65+*	15.60	20.74

$200,000 - $499,999		
AGE	**Non-Tobacco**	**Tobacco**
<35	0.71	1.17
35-39	1.10	1.88
40-44	1.32	2.41
45-49	2.49	4.06
50-54	3.34	7.08
55-59	5.62	11.54
60*	7.17	13.43
61*	7.95	14.21
62*	9.12	14.75
63*	10.14	15.45
64*	12.17	17.17
65+*	13.26	17.62

$500,000 to $1,000,000		
AGE	**Non-Tobacco**	**Tobacco**
<35	0.68	1.12
35-39	1.05	1.78
40-44	1.25	2.29
45-49	2.38	3.85
50-54	3.17	6.73
55-59	5.33	10.96
60*	6.81	12.76
61*	7.56	13.49
62*	8.67	14.02
63*	9.63	14.68
64*	11.56	16.32
65+*	12.59	16.74

* Rates are for renewal purposes only for those up to age 65.

Rates shown are guaranteed until June 30, 2021.

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.

- Children's semiannual rate: $9.58 for $10,000 of coverage
  $24.02 for $25,000 of coverage
  ($2,000 and $5,000 respectively for children ages 14 days to 6 months)
- Employees may only have up to $250,000 in coverage.
- At age 70, member benefits are reduced to 50% of the original amount or $50,000 (whichever is less). Spouse and domestic partner coverage terminates at age 70.
- Premium rates are based on your age and increase as you enter new age brackets. Your age is your age on the policy anniversary date.
- Coverages starting at $200,000 and again at $500,000 reflect a discount for volume purchases.
- If you choose the Accidental Death & Dismemberment (AD&D) option you will receive the same level of coverage as your Term Life Insurance. The AD&D annual rate is $.36 per $1,000 of coverage.

ADDITIONAL PLAN FEATURES

Accelerated Life Benefit Option Lets You Benefit From Your Own Plan

You may use the proceeds received from this benefit for any purpose. You must have at least $20,000 in Life Insurance coverage in force to qualify for this benefit. This benefit can be of value when a terminal illness creates a need for funds to help pay for medical expenses or nursing care. For example, if an insured member is diagnosed as terminally ill, as defined in the certificate, he/she can receive 50% of his/her insurance amount ($150,000 maximum). 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.

Premiums Waived if You Become Totally Disabled

If an insured member, spouse or domestic partner becomes totally disabled (as defined in the certificate) prior to age 60, and remains continuously disabled for six consecutive months, this coverage will remain in effect until age 70 - at no cost to the insured - as long as he/she remains totally disabled.

For employees of members, this coverage will remain in effect until the date of the employee's retirement.

Conversion Privileges

When member or employee coverage terminates or reduces, it may be converted to an individual whole life policy within 31 days - without regard to your health at that time. This privilege also applies to spouse or domestic partner and child coverage.

Contribution Credits

When the Plan's claims experience is favorable, contribution credits may be granted and used, to reduce insured members', spouses/domestic partners and employees' premium. The Plan has had past credits. Future credits, which cannot be guaranteed, can only be used to reduce amounts due and are not available if coverage is terminated.

Choice of Beneficiary

Benefits will be paid to the person or entity designated by you in writing and on file with the insurance company. The member is the beneficiary of children's policy.

You may also assign ownership of this insurance to another person or entity for tax and estate planning purposes, subject to any terms and limitations contained in the group policy.

OTHER IMPORTANT INFORMATION

Effective Date

Coverage will become effective on the first of the month after the date on which coverage is approved by the insurer, provided you are actively at work. If you are not actively at work on the scheduled effective date, your insurance will begin on the date you return to work full-time.

Continuation of Coverage

A member's insurance can be renewed as long as he/ she remains a member of the MSBA, makes required contributions when due and the Group Policy remains in force. Spouse and domestic partner coverage terminates at age 70.

At age 70, member coverage will reduce to the lesser of $50,000 or 50% of the original coverage amount.
Coverage for employees reduces to 65% of the original amount at age 65, to 50% of the original amount at age 70 and to 30% of the original amount at age 75. Coverage terminates when the employee is no longer actively employed by the Member.

Children's coverage ends when they cease to be eligible dependents. If employee coverage terminates because employment with an MSBA-member firm ends, work hours reduce or the employee retires, the coverage may be continued up to the earliest of the date the insured becomes eligible under any Group Policy; the end of the 18-month period following the date the insured's work hours reduced to fewer than required for eligibility; or the date the group contract terminates.

Renewal Payments and Claim

Once you are approved for coverage, you will have a 31-day grace period for your payment of renewal premiums. When you want to submit claims, contact the Minnesota State Bar Association Administrator for claim forms at 1-800- 501-5776 between 7:30 a.m. and 4:30 p.m. Central Time, Monday through Friday.

Certificate of Insurance

When you become insured, you will be sent a Certificate of Insurance describing your coverage with complete provisions, limitations and exclusions.

Money-Back Guarantee

Your satisfaction is guaranteed. When you receive your Certificate of Insurance, read it carefully. If you're not completely satisfied with the terms of your new insurance Plan, simply return your Certificate within 30 days. Provided no claims have been submitted or paid, your premium will be promptly refunded. No questions asked! Your insurance will then be cancelled.

How to Apply

1. Complete the Application. (To make this insurance available at the lowest possible cost, a blood test and/or additional medical information may be required depending on age and the amount of coverage requested.)
2. Make your check for the total cost of all insurance requested payable to:
   Administrator, MSBA Group Insurance Program
3. Mail the completed Application with your check to:
   MSBA Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

Consider Your Eligibility

Before you request coverage, you must be a member in good standing of MSBA. You must be a member for 30 days before initiating your insurance requests. If you have any questions about membership, see the MSBA home page at www.mnbar.org.

Accidental Death & Dismemberment Insurance
Group Accidental Death & Dismemberment (AD&D) Insurance can be elected up to the same level of death benefit for which you are applying. MSBA Group Accidental Death & Dismemberment (AD&D) Insurance is an important addition to your benefit plan. The AD&D coverage has exclusions. Please see the Certificate for details with complete provisions, limitations and exclusions.

Questions? We're Only a Phone Call Away
If you have any questions about your eligibility, call a service representative toll-free at 1-800-501-5776 between 7:30 a.m. and 4:30 p.m. Central Time, Monday through Friday.

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 GL-29063-7, which is issued to the Minnesota State Bar Association.

This is a paid endorsement. The MSBA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

Policy Form LP08GP

Administered by:

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

QUESTIONS?
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