Office of the Administrator
P.O. Box 14464
Des Moines, IA 50306-8993

RESERVE STRENGTH
RESERVE LIFE

Reserve Officers Association of The United States Insurance Plans

Dear ROA Member,

Thank you for requesting information on ROA's Joint Term Group Life Insurance Plan–the ROA 1 Plan.

It's one plan that covers the two of you – you and your spouse[1] – for one affordable premium. And you pay for only one benefit.

If you think about it, the plan makes a lot of sense ...

You file your taxes jointly ... You save for your retirement together ... You have joint bank accounts and credit cards ... You make decisions on everything together ...

Why not one joint plan that covers both you and your spouse[1]?

By having the ROA 1 Plan on your side, you'll pocket the difference with what you'd spend for two plans. In fact, with this 1 plan and ROA's GROUP purchasing power, you may save.

Plus, ROA made sure your benefits are available for most military activities and assignments. There's no military war clause or exclusion.

In addition, with the "Death During a Hostile Action" Benefit your loved ones will collect up to an extra $25,000.00 (or your benefit amount whichever is less) if you're declared "killed in action" by the Department of Defense in a designated combat zone.

The ROA 1 Plan is an easy and affordable way to add to the life insurance coverage your family may already have.

Even if you leave your current job or if your employer cuts back on your life benefits, the ROA 1 Plan can stay with you.

(Continued...)

Because it's a joint term "first-to-die" type of life plan, it pays the benefit amount you select on whoever dies first – you or your spouse[1].

In the event both you and your spouse[1] die from the same covered accident, the ROA 1 Plan pays DOUBLE your benefit amount.

You and your family get coverage wherever you go, 24 hours a day, on active duty or not.

The ROA 1 Plan provides coverage for every member of your family at a reasonable price.

What's more as an ROA Member, you may already qualify. All you have to do is fill out the enclosed application to get the process started.

It's simple. You must supply satisfactory responses to medical questions to the insurer which you and your spouse[1] can complete now, in the comfort of your home.

Plus, the ROA 1 Plan is 100% sponsored and recommended by ROA, who's been fighting for your rights for more than 75 years.

But you don't need to make a lifelong commitment to this plan today. SEND NO MONEY NOW.

You will be sent a Certificate of Insurance detailing your coverage as soon as you're both approved by the insurer.

Read your Certificate carefully within 30 days. If you decide it's what your family needs, then simply pay your bill. If it's not what you had in mind, provided no claims have been submitted or paid, do nothing. That will end it. It's risk free!

Complete your ROA 1 Plan application today. There's absolutely nothing to lose and a lot more to gain.

Sincerely,

Anthony A. Baldus, Principal
Mercer Health & Benefits Administration LLC
ROA Insurance Plans Administrator
License #8704140

P.S. Is ROA's two-for-one Membership Benefit the best deal for you and your family? Coverage for you and your spouse[1] for the price of one and extra special military benefits at no additional cost to you.

Group Term Life Insurance underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. This is a paid endorsement. ROA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan. The group policy is sitused in the state of North Dakota and is governed by its laws. Coverage may not be available in all states.

[1]In Oregon, spouse includes domestic partner.

Policy Form #LP08GP

IJL020LA

Group Term Life Application

ROA RESERVE STRENGTH RESERVE LIFE

Please complete the entire Application. The proposed insured should fill out this application. Please print clearly in dark ink and mail to ROA ***Group Insurance Program, P.O. Box 14464, Des Moines, IA 50306-8993, or call 1-800-247-7988, or email roa.service@mercer.com.***

Reserve Officers Association | Policy No. 31816-7

1. TELL US ABOUT YOURSELF

Member's Information:

Name (Last, First, MI)			❑Male ❑Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	Email Address	

Spouse's Information:

Name (Last, First, MI)		Name 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 #	Email 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**
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 24 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 END OF APPLICATION

2. SELECT YOUR COVERAGE

Member/Spouse Amount:

❑ $100,000 (_0Y1) ❑ $50,000 (_0N1) ❑ $25,000 (_0H1) ❑ Other: $_____ *in $25,000 increments (Minimum: $25,000 Maximum: $200,000)*

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

❑ $5,000 Dependent Child(ren) Coverage

Your ROA Joint Term Life benefits will be paid to your spouse. If you would like to designate a different beneficiary, please complete below. Beneficiary for dependent child(ren) coverage (if elected) will be the member under the certificate to which the dependent child(ren) coverage is attached.

_____

(Beneficiary Name) (Address) (Home/Cell Phone #) (Social Security Number) (Relationship)

3. PROVIDE YOUR HEALTH INFORMATION

Member: **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:

Member :_____ Spouse:_____

_____ _____

	Member	Spouse	Children
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having the HIV infection or AIDS (Acquired Immunodeficiency Syndrome)?	❑ Yes ❑ No	❑ 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	❑ Yes ❑ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?	❑ Yes ❑ No	❑ 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	❑ Yes ❑ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?.....	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?.....	❑ Yes ❑ No	❑ 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	❑ 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	❑ 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	❑ 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	❑ Yes ❑ No

a. Member driver's license number and state of issue:_____

b. Spouse's driver's license number and state of issue:_____

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION (continued)

	Member	Spouse	Children
7) Have you ever applied for insurance that was declined, postponed or modified in any way?	❑ Yes ❑ No	❑ 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	❑ 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				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				

4. 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 END OF APPLICATION

5. 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 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's Signature (always required)	Date

SEND NO MONEY NOW!

GRPLIFEJTLROA14-ND ReliaStar Life Insurance Company, Minneapolis, MN (07/14)

NOTICE APPLICABLE TO OREGON RESIDENTS

The fraud warning contained on any application/enrollment form contained in this solicitation is not applicable to Oregon residents.

The following fraud notice is applicable to Oregon residents only.

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 may be committing a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

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. 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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The ROA 1 Plan Joint Group Term Life Insurance Plan

1 Plan Covers Both • 1 Affordable Price

Coverage for you and your spouse[1] in one plan

Why is the ROA 1 Plan better for my family than all the other life plans available today?
The ROA 1 Plan is unique. Some life plans today make you buy separate coverage for you and your spouse[1] – which may cost you twice as much. With the ROA 1 Plan, you get coverage for both you and your spouse[1] in one plan. It's a simple equation:

ROA 1 Plan = 1 (you) + 1 (your spouse[1])

The ROA 1 Plan also costs less than the price of two separate plans. Plus, the Plan was custom-tailored by ROA Members like you, and it offers benefits you may not find in any other life plan. The ROA 1 Plan is exclusive to ROA Members and is only available to you here.

What is the ROA 1 Plan and how does it work?
The ROA 1 Plan is a joint term "first-to-die" life plan. You and your spouse[1] are both covered for the same benefit amount — it pays the benefit you select on whoever dies first — you or your spouse[1].

Will it cover my family and me while I'm on active duty?
Yes, you're covered for most of your military activities. And because of ROA's exclusive "Death During a Hostile Action" Benefit, your spouse[1] will receive up to $25,000.00 in addition to your basic life benefit if the DoD declares you're killed in action in a designated combat area. This benefit is exclusive to ROA.

Plus, there's coverage for military flyers. If your death results from service, training, or instruction as a pilot or crew member on a military aircraft before age 35, one half of your benefits will be payable to your spouse[1].

What is the common accident benefit?
This benefit provides that if both you and your spouse[1] die in the same covered accident, your children will receive DOUBLE your benefit amount. For example, if you select $100,000 of benefits, then $200,000 will be paid ($100,000 for each life).

How much coverage can my spouse[1] and I get?
You and your spouse[1] under age 65 can apply for $25,000.00, $50,000.00, or $100,000.00 of coverage. The choice is yours.

What about our children?
You can apply for a $5,000.00 benefit for your unmarried, dependent children age 6 months to age 19 (or 25 if they are full-time students). ($500 for children age 14 days to 6 months.)

How much does the ROA 1 Plan cost?
Your monthly rate depends on three factors: the benefit amount you select; the tobacco user status of you and your spouse[1]; and the age difference between you and your spouse[1].

NON-TOBACCO USERS: If you and your spouse[1] are not tobacco users and the difference between your ages is 5 years or less, refer to TABLE A for your affordable monthly rate. If you're more than 5 years in age apart, refer to TABLE B.

TOBACCO USERS: If either you or your spouse[1] use tobacco and the difference between your ages is 5 years or less, refer to TABLE C. If you're more than 5 years in age apart, refer to TABLE D.

Table A – Monthly Rate
Non-Tobacco User Age < 5 year difference

Oldest Spouse's[1] Age	$25,000 Benefit	$50,000 Benefit	$100,000 Benefit
Under 30	$3.02	$6.04	$12.08
30–34	3.23	6.46	12.92
35–39	3.88	7.75	15.50
40–44	5.71	11.42	22.83
45–49	8.98	17.96	35.92
50–54	13.71	27.42	54.83
55–59	20.44	40.88	81.75
60–64	30.94	61.88	123.75
65–69	66.31	132.63	265.25

(Next page, please)

Table B – Monthly Rate
Non-Tobacco User Age > 5 year difference

Oldest Spouse's[1] Age	$25,000 Benefit	$50,000 Benefit	$100,000 Benefit
Under 30	$2.96	$5.92	$11.83
30–34	3.13	6.25	12.50
35–39	3.79	7.58	15.71
40–44	5.13	10.25	20.50
45–49	7.71	15.42	30.83
50–54	11.71	23.42	46.83
55–59	17.71	35.42	70.33
60–64	26.98	53.96	107.92
65–69	59.85	119.71	239.42

Table C – Monthly Rate
Tobacco User Age < 5 year difference

Oldest Spouse's[1] Age	$25,000 Benefit	$50,000 Benefit	$100,000 Benefit
Under 30	$3.67	$7.33	$14.67
30–34	3.90	7.79	15.58
35–39	4.69	9.38	18.75
40–44	6.90	13.79	27.58
45–49	10.85	21.71	43.42
50–54	16.60	33.21	66.42
55–59	24.73	49.46	98.92
60–64	37.44	74.88	149.75
65–69	80.21	160.42	320.83

Table D – Monthly Rate
Tobacco User Age > 5 year difference

Oldest Spouse's[1] Age	$25,000 Benefit	$50,000 Benefit	$100,000 Benefit
Under 30	$3.58	$7.17	$14.33
30–34	3.77	7.54	15.08
35–39	4.58	9.17	18.33
40–44	6.21	12.42	24.83
45–49	9.33	18.67	37.33
50–54	14.17	28.33	56.67
55–59	21.42	42.83	85.67
60–64	32.65	65.29	130.58
65–69	72.42	144.83	289.67

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 Coverage $5,000 Benefit: 95 cents per month covers all eligible children.

The rates in this fact sheet will not be changed unless rates change for all insureds in your classification. Your rates are based on the older spouse's[1] attained age and increase as the older spouse[1] enters a higher age bracket. Rates shown are guaranteed until 10/31/2022. You will be billed quarterly for your convenience.

Can our coverage be cancelled if either of us gets sick?
No. Your coverage continues as long as:

- You remain an ROA Member.
- You pay your premiums when due.
- You and your spouse[1] are living and are under age 70.
- The group policy remains in force.
- You remain married.

Coverage for your children continues as long as yours does, so long as they remain eligible.

Who will collect the benefits?
If you die first, then your spouse[1] will automatically collect all the benefits. If your spouse[1] dies first, then you collect the benefits. If both of you die from the same accident, the benefits will be paid to your surviving children. If you have no children, the benefits will be paid to your parents, siblings and then estate in this order. Your children's beneficiary will be the member first, then your spouse[1], your child's siblings, then your parents, then your siblings, then estate, in this order. (If you wish to designate another beneficiary, please contact the Plan Administrator in writing.)

Can we keep the plan after one of us dies?
If you or your spouse[1] die, the surviving spouse[1] and covered children can elect coverage under the ROA Term Life Plan, Group Policy No. GL-31816-7, (provided a request for such coverage is made within 31 days after you or your spouse's[1] death and you or your spouse[1] continue to pay your premiums).

How soon will our ROA 1 Plan coverage begin?
Once your application is approved by the insurer, your coverage will start on the first of the month following the approval date of your application and the receipt of your first premium payment. (If you or your spouse[1] are hospitalized at this time, then coverage will begin the day after you're released.) Your children's coverage begins on the latest day of the date you become insured, the date the dependent is eligible, or the date ReliaStar Life approves satisfactory evidence that your children are insurable and you pay your premium. (If dependent is hospitalized at this time, then coverage will begin the day after dependent is released.)

Who is the Insurance Company for the ROA 1 Plan?
ReliaStar Life Insurance Company (ReliaStar Life) is the insurance company for the ROA 1 Plan. ReliaStar Life Insurance Company is a member of the Voya® family of companies.

(Next page, please)

How do we apply for the ROA 1 Plan?
Just fill out the enclosed ROA 1 Plan application and mail it in. (There's a return envelope for your convenience.)

DON'T SEND ANY MONEY NOW!

You'll receive a Certificate of Insurance once you're both approved by the insurer. Read your Certificate carefully within 30 days. If you decide it's what your family needs, then simply pay your bill. If it's not what you had in mind, provided no claims have been submitted or paid, do nothing. That will end it. It's risk free! (All applications are subject to evidence of insurability satisfactory to ReliaStar Life Insurance Company. The Company reserves the right to decline coverage for any applicant who does not meet its underwriting requirements.)

If I have a question about our coverage, what kind of help can I expect?
When you have questions, just call the ROA toll-free hotline 1-800-247-7988. Our phones are staffed by service experts who understand your ROA Life Plan inside and out. You'll get fast courteous service and accurate answers.

Administered by:

Mercer

Mercer Consumer,
a service of Mercer Health & Benefits Administration LLC
P.O. Box 14464
Des Moines, IA 50306-8993

QUESTIONS?
Call: 1-800-247-7988
E-mail: www.roainsure.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

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 group policy is sitused in the state of North Dakota and is governed by its laws. This is a paid endorsement. ROA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

[1]In Oregon, spouse includes domestic partner.

Policy Form LP08GP

Coverage may not be available to residents of all states.

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