



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

Dear ROA Member,

Thank you for inquiring about the Reserve Officers Association Group Insurance Program. Enclosed you'll find the information you requested for the following plan: 10 Year Group Level Term Life Insurance Plan. Once your application is received and approved by the insurer, you will be sent your new ROA Level Term Life Insurance Certificate.

Then you'll be on the road to taking full advantage of one of your most valuable ROA member benefits.

With the ROA Level Term Life Plan, you can take advantage of flexible benefit amounts from 100,000.00 to \$500,000.00, with relatively low group rates that are designed to remain the same for 10 years*.

And there's more...

Your membership in ROA, combined with the group purchasing power of ROA members, helped secure valuable benefits for you. These extra benefits are included in your ROA Plan:

- **You get an exclusive 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.
- **You can collect up to 50% of your ROA Level Term Life benefit** (or \$100,000.00, whichever is less) if you become terminally ill as defined in your Certificate with less than six months to live. You can use this "living benefit" any way you want. Your beneficiary will then receive the remainder of your life insurance benefit at your death. 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.

- **You're covered 365 days a year, wherever you are.** The only exclusion is suicide within the first year of the date your insurance or increase in insurance starts. The Accelerated Life Benefit and the AD&D Benefit are subject to additional exclusions.
- **You pay no premiums if you're disabled.** Your coverage will continue at no cost to you if you become continuously totally disabled for at least nine consecutive months and if your disability occurs before age 60, as defined in the certificate.
- **Your spouse¹ and dependent children may qualify for coverage too.** Simply check the box on the back of the application and we'll send you more information and an application.
- **Your beneficiary may be able to collect an immediate emergency benefit.** Your primary beneficiary may be eligible for an immediate death benefit of up to \$5,000.00 within 24 hours of your death. This benefit is designed to help with the immediate expenses surrounding the death of a member. The remaining benefits will be paid as soon as the claim process has been completed.
- **Voya Travel Assistance Service.**** What if you or your spouse¹ is traveling (more than 100 miles from your home-even abroad) and you're in an accident, lose your passport or need other assistance? This program can help you plan your trip and deal with potential problems you may have while traveling at no additional cost to you. Think of this as your own personal travel assistance team on-call 24 hours a day, every day, from anywhere you might be that's away from home, or even abroad!
- **Funeral Planning, Will Prep & Concierge Service.***** Offers you and your family access to funeral planning assistance and negotiation at the time of need as well as pre-planning tools and Will Prep services that can be used to research and document decision and wishes, at no additional cost to you.

I need to hear from you today.

Please take a few minutes right now to complete your application. Then return it in the enclosed postage-paid envelope. Don't send any money now. Once your application is approved by the insurer, we will then send you a bill.

Apply today. (Remember this rate is designed to remain level for 10 years.*)

Sincerely,



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

P.S. You will be sent your Official ROA Group Level Term Life Plan Certificate, issued by ReliaStar Life Insurance Company, as soon as your application is approved by ReliaStar Life.

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

**Voya Travel Assistance services provided by EuropAssistance USA, Bethesda, MD. Services are not available in OR.

***Funeral Planning, Will Prep and Concierge Services provided by Everest Funeral Package, LLC, Houston, TX.

¹In Oregon, spouse includes domestic partner.

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 situated in the state of North Dakota and is governed by its laws. Coverage may not be available in all states. Policy form LP08GP.

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.

Group Term Life Insurance underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies.

ILL020L - ROA

Group Term Life Application for 10-Year Level Term Rate



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@mercero.com.**

Reserve Officers Association	Policy No. 31816-7
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1. TELL US ABOUT YOURSELF

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

Name (Last, First, MI)				<input type="checkbox"/> Male <input type="checkbox"/> 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 (complete this section only if applying for Spouse coverage on this application):

Name (Last, First, MI)				Name of Member		<input type="checkbox"/> Male <input type="checkbox"/> 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 #

- | | <u>Member</u> | <u>Spouse</u> |
|--|---|---|
| a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?
Date of last use (month/year): | <input type="checkbox"/> Yes <input type="checkbox"/> No
_____ / _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No
_____ / _____ |
| b) Are you currently working less than 24 hours per week at your regular occupation and place of business? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please explain: _____

PLEASE COMPLETE AND SIGN END OF APPLICATION

2. SELECT YOUR COVERAGE

Member Amount: 10-Year Level Term

\$500,000 \$250,000 \$100,000 Other: \$ _____ in \$5,000 increments (Minimum: \$100,000 Maximum: \$500,000)

Spouse Amount: 10-Year Level Term

\$500,000 \$250,000 \$100,000 Other: \$ _____ in \$5,000 increments (Minimum: \$100,000 Maximum: \$500,000)

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

Member Accidental Death & Dismemberment

Spouse Accidental Death & Dismemberment

\$10,000 Dependent Child(ren) Coverage*

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

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: _____

	<u>Member</u>	<u>Spouse</u>
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)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

- 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
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member <input type="checkbox"/> 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 Coverage (complete this section only if applying for Member coverage on this application)

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

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

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

PLEASE COMPLETE AND SIGN END OF APPLICATION

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

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

Option 1: AUTOMATIC CHECK WITHDRAWAL REQUEST: Monthly Quarterly

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

Checking Account

Routing #: _____ Account #: _____

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

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

Option 2: DIRECT BILL: Quarterly Semi-Annual Annual

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

6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I 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.

PLEASE COMPLETE AND SIGN END OF APPLICATION

6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW (continued)

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

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

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

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

SEND NO MONEY NOW!

GRPLIFEUW14-ND

ReliaStar Life Insurance Company, Minneapolis, MN

(7/14)

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.

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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. 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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ROA Group Level Term Life Insurance Benefit Notification

As a member in good standing in the Reserve Officers Association of the United States, you can now qualify to apply for ROA Group Level Term Life coverage.

Monthly Rates For The 10-Year Level Term Life Plan				
Your rate for the entire term of your coverage is the rate for your age at the time coverage is issued.*				
Age	\$100,000		\$200,000	
	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
35	\$4.60	\$16.10	\$9.20	\$32.20
36	4.70	17.30	9.40	34.60
37	4.80	18.60	9.60	37.20
38	5.10	20.00	10.20	40.00
39	5.30	21.60	10.60	43.20
40	5.80	23.30	11.60	46.60
41	6.30	25.20	12.60	50.40
42	7.00	27.20	14.00	54.40
43	7.80	29.30	15.60	58.60
44	8.60	31.60	17.20	63.20
45	9.50	33.80	19.00	67.60
46	10.40	36.00	20.80	72.00
47	11.30	38.30	22.60	76.60
48	12.20	40.80	24.40	81.60
49	13.30	43.60	26.60	87.20
50	14.70	46.60	29.40	93.20
51	16.20	50.00	32.40	100.00
52	18.00	53.60	36.00	107.20
53	19.90	57.50	39.80	115.00
54	22.20	61.70	44.40	123.40
55	24.50	66.20	49.00	132.40
56	26.80	70.70	53.60	141.40
57	29.30	75.40	58.60	150.80
58	32.10	80.90	64.20	161.80
59	35.30	87.80	70.60	175.60
60	39.10	97.30	78.20	194.60

Rates shown are as of 9/1/2021.

Coverage of \$10,000 is available for your children at a monthly rate of \$2.00. One premium covers all eligible children age 14 days but less than 21 years (23, if full time student).

If you choose the optional Accidental Death & Dismemberment (AD&D) benefit, you will receive the same level of coverage as your Term Life Insurance. The AD&D monthly rate is \$0.03 per \$1,000.

You will be billed quarterly for your convenience. Coverage will not be reduced during your level term period.* The level term rate period begins on the effective date assigned by ReliaStar Life. Plan benefits are offered for amounts \$100,000 to \$500,000. The 10-year plan is offered for persons aged 19-60. The 20-year plan is offered for persons aged 19-50. To obtain a rate quote for other ages, benefit amounts, or for information on the 20-year Level Term Life Plan, call toll-free 1-800-247-7988.

*Premiums are based on your age at date of issue and will not increase due to your age or health status. Premiums will only be increased if premiums are increased for all insureds in the same age and rate class. The initial premium will not change for the first ten years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

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.

Three Reasons to Choose ROA Level Term Life Insurance

1. Your rates and benefit amount are designed to stay the same for 10 years.*
2. You'll pay economical group rates. You have the buying power of ROA to help keep the premiums economical.
3. Your satisfaction is 100% guaranteed. You have 30 days to review your certificate. If you're not happy with the plan, simply write "cancel" on your certificate and mail it back to us, within 30 days, provided no claims have been submitted or paid. There's no obligation.

Qualifications for this ROA Level Term Life Plan offer are few:

- You must be a Reserve Officers Association member 19-60 years of age for the 10-year plan (19-50 years of age for the 20-year plan).
- You must be actively at work.
- You cannot already be insured by this plan.

For members and spouses¹, beginning on and after the 70th birthday, ReliaStar Life decreases the amount of your insurance. ReliaStar Life pays a percentage of the amount otherwise payable—

- From your 70th birthday to age 75, ReliaStar Life pays the lesser of 50% or \$50,000. For members and spouses¹, insurance terminates on the Group Policy anniversary date on or after your 75th birthday.

A decrease in the amount of insurance due to age will take effect on the later of your attainment of any of the specified birthdays, or at the end of a level term rate period. Your amount of insurance will not decrease due to age during a level term rate period.

If ReliaStar Life approves the insurance, premiums will be determined on a Level Term Rate Period basis if all of the following conditions are met:

- The amount of insurance requested is \$100,000 or greater.
- Your attained age is under age 61 at the time of application.
- Your application form indicates premiums are to be paid on a level term basis.

If all of the above conditions are not met, premiums will be based on your attained age as it falls in the appropriate 5-year premium age bracket.

All members and spouses¹ must complete an application form for any new coverage or to increase coverage (including dependent coverage) or to begin an initial or subsequent 10-year Level Term Rate Period when proof of good health is required. Some applicants may be required to have a medical exam in order to apply for coverage. For more information on medical requirements, please contact your plan administrator.

If there is an increase in the amount of your insurance, the increase will take effect on the first day of the month on or next following the date of the increase. If you are in a Policy Form #LP08GP

Level Term Rate Period, premiums for the increased amount of insurance will be based on your attained age on the effective date of the increase.

Your ROA Level Term Life Plan will start on the first day of the month after your application has been approved by the insurer and your first premium has been paid.

Accidental Death & Dismemberment Insurance Benefit Option

Group Accidental Death & Dismemberment (AD&D) Insurance can be elected up to the same level of death benefit being applied for. In addition, many people are seriously injured by accidents and sustain loss of limb or eyesight. For these reasons, the ROA Group Accidental Death & Dismemberment (AD&D) Insurance is an important addition to your benefit plan.

KEEP THIS INFORMATION WITH YOUR IMPORTANT PAPERS

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Complete details can be found in Group Policy 31816-7. The group policy is situated in the state of North Dakota and is governed by its laws. Coverage may not be available in all states. This is a paid endorsement. ROA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

Administered by:



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
Web: www.roainsure.com

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Group Term Life Insurance Underwritten by:

ReliaStar Life Insurance Company
Minneapolis, MN

Policy form LP08GP.

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

¹In Oregon, spouse includes domestic partner.