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

Dear ROA Member,

The enclosed Application confirms your pre-registered status in connection to Senior Group Term Life Insurance extended exclusively to a select group of ROA Members.

> Called ROA V.I.P., your newest member privilege is a powerful term life insurance benefit add-on negotiated specifically for Members in good standing over age 50 (spouses of ROA members over age 45).

Please let me explain:

At an age when many veterans report that adding extra life insurance benefits often proves nearly impossible, you can now easily add $10,000.00 ... $25,000.00 ... up to $50,000.00 in life insurance to your family's financial protection.

You don't need a medical exam. You don't need your doctor to send in your medical records.

All it takes is a few satisfactory answers to the insurer on the enclosed Application and we'll get the paperwork going on as much as $50,000.00 in ROA V.I.P. group term life insurance benefits.

ROA V.I.P. was carefully developed as an extra term life safety net for Members like you (and your spouse if you'd like).

No one else can activate these benefits.

It's a "reward" reserved exclusively for selected ROA Members — to thank you for your service to our country and your dedication to ROA.

EXTRA MONEY FOR YOUR LOVED ONES... JUST WHEN OTHER BENEFITS TOO OFTEN FADE AWAY

Members of ROA frequently report their family's life insurance coverage starts dwindling after age 50.

Sometimes the culprit is employer-sponsored life insurance benefits that stop after an ROA Member switches jobs or retires. Others point to coverage they bought when they were younger — that's now drastically reduced as they get older.

(Continued...)

Regardless of the reason, the end result is the same:

> Not enough money to pay off a mortgage or big medical bills. Not enough money to take care of final expenses or funeral costs.
>
> Not enough to make ends meet as families struggle to put their lives back together.

But today you can set up extra life insurance worth $10,000.00 ... $25,000.00 ... or $50,000.00. Sent straight to your family just when they need it most.

Just take advantage of your revised Member's privileges to request your new ROA V.I.P. term life insurance benefits right away.

FULL ROA V.I.P. BENEFITS START ON DAY 1

As you'd expect, ROA V.I.P. kicks in with full-dollar benefits — starting on Day 1 following approval of your application and your premium is received.

> There are no "hidden gotchas" before coverage begins.
>
> Benefits are not limited to situations like accidents or certain medical conditions.
>
> Benefits are not delayed until you've been covered for a certain amount of time.

You start out with 100% coverage on the very first day of your ROA V.I.P. term life coverage. And you're covered for everything except suicide during the first year.

PRE-REGISTRATION MEANS NO MEDICAL EXAM REQUIRED

Plus, your status as a pre-registered ROA Member entitles you to simplified enrollment privileges when you request benefits in the next 10 days.

> There are no physicals involved. Your acceptance is based on your answers to 4 simple questions on the enclosed Form.
>
> You don't even have to be actively at work.

As an ROA Member over age 50, everything you need is included right here in this revised benefit documentation packet.

Please provide us with the necessary information regarding your ROA Member status and record of service on the Application. Then answer a few questions to confirm your current health and sign where indicated.

You don't even send money today.

ROA GROUP RATES

And what about the rates for your new ROA V.I.P. term life benefits? They're probably much lower than you'd expect.

> Take a 54-year-old Member, for example. Only 74¢ a day sets up a $25,000.00 safety net. Just an extra 74¢ a day doubles the cash benefits to $50,000.00.

And adding your spouse is an even better bargain. All it takes is 42¢ a day to add a 54-year-old spouse for $25,000.00 ROA V.I.P. benefits.

(Continued...)

UNCONDITIONAL 100% MONEY-BACK GUARANTEE

Of course, there's no risk when you request your ROA V.I.P. privileges in the next 10 days.

Just mail back your completed Application to get the paperwork started on your ROA V.I.P. term life benefits. We'll mail your official Certificate of Insurance as soon as coverage is approved.

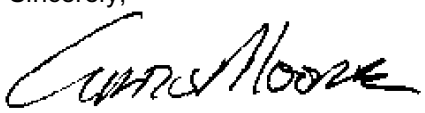
Look it over for 30 days. You don't pay a penny until you're fully satisfied. If ROA V.I.P. isn't what you had in mind, just let us know within 30 days. You'll get a 100% refund of any money you may have sent, provided no claims have been submitted or paid. **No hassles and no questions asked.**

But it's important to act on this change to your ROA Member benefit status right away.

Pre-registration (and your "no-medical-exam" enrollment privileges) cannot be extended indefinitely.

That's why I must urge you to mail your completed Application within the next 10 days.

Sincerely,



Curtis Moore, Partner
ROA Insurance Plan
License #16957209

P.S. Your Pre-Registration status now entitles you to request full ROA V.I.P. term life benefits — with NO medical exam or extra paperwork required.

Please act on your new V.I.P. privileges by mailing your Application within the next 10 days.

Products and services provided by ReliaStar Life Insurance Company, 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.

Policy Form # LP08GP

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Senior Group Term Life Application

Please use this form to apply for **Simplified Issue** coverage. 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. Our hearing impaired or voice-impaired members may call the Relay Line at 1-800-855-2881.***

Reserve Officers Association — Policy No. 31816-7

1. Tell us about yourself.

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

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

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	

2. Please check which ROA V.I.P. Senior Life benefits you would like.

Member Amount (Age 50-74): ☐ $50,000 (_0N1) ☐ $25,000 (_0H1) ☐ $10,000 (_0E1)

Spouse Amount (Age 45-74): ☐ $50,000 (_0N5) ☐ $25,000 (_0H5) ☐ $10,000 (_0E5)

		Member	**Spouse**
a.	In the past 2 years, have you been disabled due to sickness or injury?	☐ Yes ☐ No	☐ Yes ☐ No
b.	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:_____

Your ROA V.I.P. Senior Life benefits will be paid to your spouse, children, parents or estate (in that order). The member is the beneficiary for spouse coverage. If you would like to designate a different beneficiary, please complete below.

_____

(Beneficiary Name) (Address) (Social Security Number) (Relationship)

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PLEASE ANSWER THE FOLLOWING QUESTIONS.

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

	Member	Spouse
1. Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke, cancer/tumor, diabetes, seizures, AIDS (Acquired Immunodeficiency Syndrome) or the HIV infection?	☐ Yes ☐ No	☐ Yes ☐ No
b. memory loss, Alzheimer's disease, dementia, depression or any other mental/nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. disease or disorder of the heart, lungs, liver or kidneys?	☐ Yes ☐ No	☐ Yes ☐ No
d. disease or disorder of the blood, or neurological, immune, digestive or intestinal system?	☐ Yes ☐ No	☐ Yes ☐ No
2. 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
3. In the past 2 years, have you been hospitalized or admitted to a medical care facility (or been advised by a member of the medical profession to do so), or had medical tests, procedures or treatments recommended by a member of the medical profession that have not yet been performed?	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you receive in-home medical care or need personal or mechanical assistance in walking, bathing or dressing?	☐ 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				
	☐ Member ☐ Spouse				

PLEASE COMPLETE AND SIGN END OF APPLICATION

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. Please read, sign and date.

- 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	Date	Spouse's Signature (if applying)	Date

SEND NO MONEY NOW!

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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THE ROA V.I.P. GROUP TERM LIFE INSURANCE PLAN

Senior Group Term Life Insurance

- Please act on this "No-medical exam" offer by mailing your application within 10 days.
- Pending receipt of Application to confirm $10,000.00, $25,000.00 or $50,000.00 benefit selection and verify health status.
- Once put in force, full benefits start on day 1 of coverage.

ROA V.I.P. Group Term Life Insurance Plan

Monthly Group Rates

Attained Age - Member & Spouse	$10,000.00		$25,000.00		$50,000.00	
	Male	Female	Male	Female	Male	Female
45-49*	$6.70	$4.60	$16.75	$11.50	$33.50	$23.00
50-54	$9.20	$5.20	$23.00	$13.00	$46.00	$26.00
55-59	$13.80	$7.90	$34.50	$19.75	$69.00	$39.50
60-64	$20.00	$13.20	$50.00	$33.00	$100.00	$66.00
65-69	$30.90	$22.30	$77.25	$55.75	$154.50	$111.50
70-74	$43.10	$33.80	$107.75	$84.50	$215.50	$169.00

For your convenience, you will be billed just four times a year. 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. Rates shown are guaranteed until 11/01/2015 only. Coverage begins on the first day of the month following approval by the Insurer and payment of first premium. Coverage continues with no decrease in benefits until you reach age 75. At age 75, benefits reduce to 50%. At age 80, benefits reduce to 25% of original face value. At age 85 and after, benefits will be $2,500.00. Coverage cannot be canceled as long as you remain a Member of the Reserve Officers Association, pay your premiums when due and the group contract remains in effect.

This information is a brief description of important features of the ROA V.I.P. Group Term Life Insurance Plan. It is not a contract. Terms and conditions of coverage are set forth in group policy 31816-7 issued to the Reserve Officers Association. Full details are contained in the Certificate of Insurance, which will be issued to persons who become insured under the Plan. This Plan may not be available to residents of all states. Availability may change. Policy form LP08GP. 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.

***ROA members' Spouses ONLY can apply for coverage starting at age 45 (through age 74). ROA members can apply for coverage starting at age 50 (through age 74).**

Issued by ReliaStar Life Insurance Company, a member of the Voya™ family of companies.

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 Ins. Lic.#303439
CA Ins. Lic.#0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

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