

ING TERM APPLICATION

DO

- Do print in dark ink.
- Do obtain all the necessary signatures.
- Do complete Agent's Report.
- Do have applicant initial all changes.
- Do present the Proposed Insured with the following forms:
 - Consumer Privacy Notice (If a copy will not be presented to Owner.)
 - Authorization for Release of Health Information (A completed copy must also be submitted with the application.)
 - Valuable Information About Your Term Life Insurance Purchase (If a copy will not be presented to Owner.)
- Do present the Owner with the following forms:
 - Consumer Privacy Notice (If a copy will not be presented to Proposed Insured.)
 - Conditional Receipt, when premium has been accepted and the form has been completed and signed. (One copy must be completed and submitted. The second copy is for the Owner's records.)
 - Valuable Information About Your Term Life Insurance Purchase (If a copy will not be presented to Proposed Insured.)
- Do complete the Accelerated Benefit Rider Disclosure and submit with the application.
- Do have all checks made payable to ReliaStar Life Insurance Company.
- Financial Supplement - Must be completed by the Proposed Owner and Proposed Insured(s) when:
 - Proposed Insured(s) is age 65 or older; and
 - The total face amount for all life insurance applications (formal and informal) on the life of the Proposed Insured(s) that you have submitted (or expect to submit) to the ING Life Companies equals \$1 million or more.

DO NOT

- Do not use pencil or correction fluid.
- Do not attempt to waive any of our requirements or any information that we request; you do not have the authority to make or modify contracts.
- Do not promise or imply that we will provide insurance.
- Do not accept payment in the form of cash/currency or Traveler's checks.
- Do not accept a check or money order made payable to you or with the payee left blank.
- Do not accept payment if the Proposed Insured's age nearest birthday exceeds 70 years or is less than 15 days.
- DO NOT ACCEPT MONEY OR ISSUE THE TEMPORARY INSURANCE RECEIPT IF:
 - any representations in Section I of the Temporary Insurance Receipt are answered "**Yes,**" or **left blank**; or
 - the amount applied for under the application exceeds \$1 million.
- If a premium payment is made, give the second copy of the Temporary Insurance Receipt to the Applicant/Owner. The first copy must be sent to the Administrative Office. No agent has the authority to alter the provisions of the Temporary Insurance Receipt. Additional state limitations may be added upon notification by ReliaStar Life Insurance Company. The Applicant/Owner should understand all provisions of the Temporary Insurance Receipt.

MAILING OR FAXING INSTRUCTIONS

Mail or Fax all completed materials to the Administrative Office.

Mail to:

ING Service Center
P.O. Box 5052
Minot, ND 58702-5052

Fax to:

866-308-7743
Attn: ING Service Center

TERM APPLICATION

ReliaStar Life Insurance Company, Minneapolis, MN

A. PRODUCT INFORMATION

- 1. Initial Term Period: [] 10 Year [] 15 Year [] 20 Year [] 30 Year [] Other
2. Face Amount \$
3. Location of Sale (city, state) Date

B. RIDER INFORMATION Select only if available with product. Not all riders are approved in all states.

- [] Waiver of Premium Rider
[] Children's Insurance Rider (Complete Children's Insurance Rider Application.) \$
[] Other \$

C. PROPOSED INSURED INFORMATION

- 1. First Name MI Last Name
2. Date of Birth Birth State and Country
3. Sex: [] M [] F Marital Status: [] Married [] Separated [] Divorced [] Single [] Widowed
4. SSN/Government Issued ID# Phone
5. Driver's License Number and State
6. Residence Address (P.O. Boxes are not permitted, other than APO/FPO) City State ZIP
7. Is the Proposed Insured a U.S. Citizen? (If "No", complete the Foreign Travel and Residence Questionnaire.) [] Yes [] No
8. Occupation (include duties)
9. Employer Employer Phone
10. Employer Address City State ZIP
11. Proposed Insured Annual Earned Income Annual Interest & Other Income
12. Total Net Worth
13. Has the Proposed Insured ever used tobacco or nicotine products of any type? [] Yes [] No
If "Yes", indicate Type Amount & Frequency Month/Year Last Used

D. PROPOSED INSURED PERSONAL HISTORY

- 1. Has the Proposed Insured ever declared bankruptcy? (If "Yes", provide details in chart below, including date discharged.) [] Yes [] No
2. Is the Proposed Insured, or do they intend to become a member of the armed forces, including the Reserves or National Guard? (If "Yes", complete Military Questionnaire.) [] Yes [] No
3. In the next 5 years, does the Proposed Insured intend to travel or reside outside the United States or Canada (other than a two week or less vacation to Western Europe or the Caribbean)? (If "Yes", complete the Foreign Travel and Residence Questionnaire.) [] Yes [] No
4. Does the Proposed Insured anticipate flying a plane (other than as a commercial pilot), racing motor boats, automobiles or motorcycles, or participating in sky-diving, hang-gliding or other hazardous activities? (If "Yes", complete the appropriate hazardous activities questionnaire.) [] Yes [] No

5. Except for traffic violations, has the Proposed Insured been the subject of or convicted in a criminal proceeding?
 (If "Yes", provide details in chart below.)..... Yes No
6. Has the Proposed Insured in the last five years had any motor vehicle accidents, alcohol or drug related convictions,
 or other moving violations while operating a motor vehicle? (If "Yes", provide details in chart below.)..... Yes No

For any "Yes" answer to questions 1, 5 or 6, please record information in the chart below.

Ques. #	Explanation

E. BENEFICIARY INFORMATION

Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.

Name (First, MI, Last)	DOB	Relationship	%	Beneficiary Type
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

If beneficiary is a Trust or Corporation, provide name and date of trust agreement and state of incorporation.

Name of Trust/Corporation _____ Date of Trust _____ State of Incorporation _____

F. OWNER (PAYOR) Complete only if owner is to be other than Proposed Insured.

1. Owner is: Individual Corporation Trust Sole Proprietorship Partnership Other _____

2. Full Name _____

3. Relation to Proposed Insured _____

4. Residence Address _____
 (P.O. Boxes are not permitted other than APO/FPO) City State ZIP

5. Billing Address _____
 City State ZIP

6. Phone _____ SSN/TIN or Government Issued ID# _____

7. Driver's License Number/State (individual only) _____ Date of Birth _____

8. Trust Contact Name _____ Date of Trust _____

9. Type of Trust: Revocable Irrevocable Purpose of the Trust _____

10. State of Incorporation _____ Name of Trustee/Corporate Officer _____

11. Does the above trustee have sole authority to act on behalf of the Trust? Yes No
 (If "No", list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees.)

G. REPLACEMENT INFORMATION (Applies to both Owner and Proposed Insured.)

If you intend to replace existing coverage, tell the Agent of your intention and answer "Yes" to the replacement questions (#2 and #3 below). State law may require the Agent to give you information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping existing coverage, indicating an intention to replace existing coverage may help you get the information you need to make a decision. If you do replace existing coverage, the new policy may contain, among other things, new suicide exclusions and contestability periods. Ask the Agent if you are unsure.

- | | Proposed Insured | | Proposed Owner | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Yes | No |
| 1. Do you have an existing or pending life insurance policy or annuity contract? (If "Yes", provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you considering using funds from an existing policy or contract to pay premiums on the policy you are applying for? (If "Yes", complete state required replacement form and provide details below.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you discontinued making premium payments, surrendered, forfeited, assigned to the insurer, or otherwise terminated an existing policy or contract or are you considering doing so? (If "Yes", complete state required replacement form and provide details below.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name	Insurance Company (Do not include group policies.)	Contract / Policy #	Account Value / Amount of Coverage	Date Issued

H. PAYMENT INFORMATION

1. Initial Payment: Check COD Credit Card (When available and selected, see #4 Credit Card Information.)
 Military Allotment (Active or retired military members must complete Military Allotment form and return to the Military finance department.)
 Civil Service Allotment (Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit must be completed.)

2. Initial Payment Amount \$ _____ Subsequent Payment Amount \$ _____

3. Frequency of Subsequent Payments:
 Annual Semi-Annual Quarterly Monthly (Complete EFT form-Appendix E)

4. Credit Card Payment (When available): Visa MasterCard Discover American Express

Full Name (Print as it appears on card) _____

Card Number _____ N/A _____ N/A _____ Expiration Date _____ N/A _____

5. Would you like to backdate your policy to save age? (If "Yes", see backdating disclosure, section M.)..... Yes No

I. MEDICAL TRANSFER STATEMENT (Complete when submitting medical examinations from another insurance company.)

1. Name of Insurance Company _____ 2. Date of Examination _____

3. To the best of your knowledge and belief, are the statements in the examination true and complete today?..... Yes No

4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 2 above? (If "Yes", please provide details below.)..... Yes No

J. REPLACEMENT VERIFICATION (For Agent use ONLY)

1. To the best of your knowledge and belief, will coverage under an existing life insurance policy or annuity contract be replaced, lapsed, surrendered, or borrowed against in relation to this application for insurance? (If "Yes", submit state required replacement forms.)..... Yes No

2. Is the Owner or the Proposed Insured considering using funds from an existing policy or contract to pay premiums on the policy being applied for? (If "Yes", complete state required replacement forms and provide details below.) Yes No

3. Has the Owner or the Proposed Insured discontinued making premium payments, surrendered, forfeited, assigned to the insurer, or otherwise terminated an existing policy or contract or are they considering doing so? (If "Yes", complete state required replacement form and provide details below.) Yes No

Company _____ Policy # _____ Amount _____

K. IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to:

ING Service Center
Life New Business
P.O. Box 5052
Minot, ND, 58702-5052.

L. STATE REQUIRED NOTICES

For Applicants in Arkansas, District of Columbia, Hawaii, Louisiana, Oklahoma and Tennessee:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime and in certain states, a felony. Penalties may include imprisonment, fine, denial of benefits, or civil damages.

The laws of the following states require that we provide these notices:

COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

KENTUCKY:

Any person who knowingly and 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.

NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OHIO:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

M. BACKDATING DISCLOSURE

As a policyholder, you may elect to backdate your policy, which enables you to gain benefits of a lower age for the purposes of calculating costs of insurance charges on your policy.

There are some inherent costs associated with your decision to backdate your policy. For each month that your policy is backdated the applicable costs of insurance charges are accumulated and deducted from your initial premium payment. If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

This page must be given to the Proposed Insured.

N. AUTHORIZATION AND ACKNOWLEDGEMENT

The undersigned Owner and Proposed Insured declare: By completing this life insurance application, I understand that I am applying for life insurance coverage issued by ReliaStar Life Insurance Company, referred to as the "Company." I understand and consent that this application and information obtained pursuant to this authorization may be used by the Company to evaluate my eligibility for life insurance. For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, clinic or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), any consumer reporting agency, or any other organization to release to the Company or their authorized representatives (including any consumer reporting agency) acting on their behalf, ALL INFORMATION requested by the Company about me and any minor children who are to be insured. This includes but is not limited to: Any medical information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and treatment of me or my minor children who are to be insured; Prescription drug records and related information maintained by physicians, pharmacy benefit managers and other sources; Any non-medical information about me or my minor children who are to be insured. By this authorization, each physician, medical practitioner, hospital, clinic or medically related facility contacted by the Company is instructed to provide the entire medical record in its possession concerning me or any minor children who are to be insured.

- I give my permission to the Company to collect consumer or investigative consumer reports about these same persons.
- I give my permission to the Company and other insurance companies affiliated with the Company to collect any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. I may revoke this permission and authorization as it applies to any information protected by 42CFR Part 2 or by applicable state law at any time by mailing the written revocation to the Company at the address on the Consumer Privacy Notice, but not to the extent action has been taken. I understand that the release of medical records will not be requested with respect to tests performed to determine the presence of the Human Immunodeficiency Virus (HIV) antibody.

For any life insurance application or other insurance transaction that I may have with the Company, I specifically consent that some or all of the information obtained by this authorization may be sent to MIB, reinsurers, the agent who solicited my application and his or her principals, employees

or contractors who process transactions regarding any insurance coverage I may have applied for or have with the Company or affiliated companies. I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy.

- I understand that I may request to be interviewed if an investigative consumer report is prepared. You may contact me between the hours of ____ am/pm and ____ am/pm. My daytime phone number is (____) _____.
- I know that I have a right to receive a copy of this form and a photocopy will be as valid as the original.
- This form will be valid for 24 months from the date shown below.
- I acknowledge receipt of the following notices: Notice Regarding Consumer Reports; Notice Regarding MIB; and Notice Regarding Information Practices.

VERIFICATION:

Each of the undersigned also declares that:

- I have read the statements and answers given in this application and affirm that they are true and complete to the best of my knowledge and belief. I understand that the Company may seek to rescind or cancel the insurance coverage if there is any material misrepresentation.
- This application consists of Part I, appendices and supplemental questionnaires, and will be the basis for any coverage issued on this application. Any coverage issued on this application will take effect only upon satisfaction of all of the Company's requirements, except as otherwise provided in the Conditional Receipt, if issued, with the same date as this application. Except where permitted expressly by statute or regulation, no agent or medical examiner has the authority to waive the answer to any question in the application, to pass on insurability, to make or alter any contract or waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, plan of insurance or benefits on this application shall be effective unless agreed to in writing by the Proposed Insured and Owner.
- I certify, under penalty of perjury, that my Social Security/tax identification number(s) is(are) shown and is(are) correct and that I am not subject to back-up withholding.

All completed materials must be sent to the Administrative Office at: ING Service Center, P.O. Box 5052, Minot, ND 58702-5052 or faxed to 866-308-7743.

Signature of Proposed Insured (if age 15 or older) _____

Signed at: (city/state) _____ Date _____

Signature of Owner (if other than the Proposed Insured) _____ Date _____

Print Owner/Trustee Name _____

Signature of Parent or Guardian (if the Proposed Insured is a minor) _____

Signature of Writing Agent _____

Print Writing Agent Name _____

Writing Agent State Lic. # _____ Writing Agent # _____

Name of Agent _____

Agent State Lic. # _____ Agent # _____

AGENT'S REPORT

To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.

Agent Name (Please Print.)	Agent ID #	% Split	General Agent #	General Agent Name

Each licensed agent will share equally unless otherwise indicated.

A. COMPLIANCE INFORMATION

- Did you obtain the Proposed Insured's Medical Declarations in person and record them in the presence of the Proposed Insured? (If "No", explain why and arrange for an exam.)..... Yes No
- Have you delivered the Consumer Privacy Notice to the Proposed Insured(s) or Proposed Owner? Yes No
- Did you meet personally with the Proposed Owner and review their government issued ID? (If "No", explain in Section D.) Yes No
- If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Insured or Proposed Owner? Yes No
- All sales materials used during the sale process were approved by the Company. The following are the approved sales materials used in my sales presentation: _____
- Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policyowner no later than at the time of the policy delivery.) The Company requires that all replacement sales are made in accordance with the Company's corporate policy. If this particular sale is NOT in accordance with the Company's corporate replacement policy, please check here and attach an explanation.
- Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? Yes No
- Have there been any discussions in which the Proposed Owner has been solicited to directly or indirectly sell, assign, settle or otherwise transfer the proposed policy (or the rights to its death benefit), or an ownership or beneficial interest in an entity that will own the proposed policy, to a life settlement company or other third party?..... Yes No
If "Yes", please provide details: _____
- Will the proposed policy on the life of the Proposed Insured(s) replace a policy that has been sold, assigned, or settled to or with a settlement or viatical company or any other person or entity? Yes No
If "Yes", please provide details: _____
- Will the premiums, now or in the future, be financed? Yes No
If "Yes", and the proposed policy is or will be financed with a loan from a lender identified in the Company's "Hybrid Premium Financing Guidelines," identify the lender below. Otherwise, identify the lender and describe the interest rate, term of the loan and required amount and type of collateral. _____
If "No," please identify the source of funds for initial and subsequent premiums, and describe any transactions of which you are aware that the Proposed Owner and/or Proposed Insured(s) engaged in, or will engage in, to generate such funds (e.g., the sale, assignment or mortgage of property). Please also describe the relationship of the source to the Proposed Owner and/or Proposed Insured(s). _____

B. PROPOSED INSURED/OWNER INFORMATION

- How long have you known the Proposed Insured? _____ 2. Are you related? Yes No How? _____
- How much insurance does the Proposed Insured's spouse own payable to the Proposed Insured or other dependents? \$ _____
- If this application is for a juvenile, please indicate the amount of life insurance in force on each parent or sibling.
Father \$ _____ Mother \$ _____ Sibling \$ _____
- Please check the Underwriting requirements ordered: Blood Profile/HOS Inspection Report MD Exam
 Treadmill EKG EKG Paramedical Exam Paramed Company _____

C. REMARKS (Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.)

D. ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent or Producer Agreement ("Agreement"), whichever is applicable, including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker/Dealer and do not hold an Agreement such that this language is inapplicable.

I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

Agent Signature(s) _____ Date _____

Contact for Requirements _____ Agent SSN _____

Agent Phone _____ Fax _____ Email _____

TEMPORARY INSURANCE RECEIPT

- ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO



Your future. Made easier. SM

Premium has been received from _____ in the amount of \$ _____ in payment of the first full modal premium for an insurance policy applied for on the life (lives) of _____ (Proposed Insured/ Proposed Other Insured), for whom an application (the "Application") dated _____ has been made to ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company"). This Temporary Insurance Receipt does not provide any coverage except as provided herein. If any of the below representations is answered YES or LEFT BLANK by the Proposed Insured(s), the agent is not authorized to accept a premium, and there will be NO COVERAGE. There also will be no coverage under this receipt if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

I. REPRESENTATIONS (For each Proposed Insured named above)

Has any Proposed Insured(s):

- a. in the past 10 years had unintentional weight loss or been advised by a licensed medical professional to have any diagnostic test or surgery not yet performed?
b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?
c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the brain or immune system?
d. attained age 70?

II. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders if issued as applied for under the Application; or (b) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All statements and answers are to the best of the knowledge and belief of the respondent(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
Coverage starts under any policy resulting from the Application; or
A policy resulting from the Application is refused; or
90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

There is no insurance coverage if:

- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
A Proposed Insured dies by suicide or intentional self-inflicted injury.
The premium check or authorized withdrawal is not honored.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Proposed Owner Name (Please print) _____ Date _____

X Proposed Owner Signature _____ Signed at (city/state) _____

Proposed Insured Name (Please print) _____ Date _____

X Proposed Insured Signature (if other than the Proposed Owner) _____ Signed at (city/state) _____

Proposed Other Insured Name (Please print) _____ Date _____

X Proposed Other Insured Signature _____ Signed at (city/state) _____

X Writing Agent Signature _____ Date _____

Writing Agent Name (Please print) _____ Agent Phone # _____

TEMPORARY INSURANCE RECEIPT

- ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO



Your future. Made easier. SM

Premium has been received from _____ in the amount of \$ _____ in payment of the first full modal premium for an insurance policy applied for on the life (lives) of _____ (Proposed Insured/ Proposed Other Insured), for whom an application (the "Application") dated _____ has been made to ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company"). This Temporary Insurance Receipt does not provide any coverage except as provided herein. If any of the below representations is answered YES or LEFT BLANK by the Proposed Insured(s), the agent is not authorized to accept a premium, and there will be NO COVERAGE. There also will be no coverage under this receipt if Section 1035 exchange paperwork is received without premium payment. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

I. REPRESENTATIONS (For each Proposed Insured named above)

Has any Proposed Insured(s):

- a. in the past 10 years had unintentional weight loss or been advised by a licensed medical professional to have any diagnostic test or surgery not yet performed?
b. ever had, or now have, any type of heart disease, stroke, or other vascular disease?
c. ever had, or now have, any type of cancer, leukemia, malignant tumor, or disorder of the brain or immune system?
d. attained age 70?

II. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders if issued as applied for under the Application; or (b) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All statements and answers are to the best of the knowledge and belief of the respondent(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage. If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
Coverage starts under any policy resulting from the Application; or
A policy resulting from the Application is refused; or
90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

There is no insurance coverage if:

- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
A Proposed Insured dies by suicide or intentional self-inflicted injury.
The premium check or authorized withdrawal is not honored.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Proposed Owner Name (Please print) _____ Date _____

X Proposed Owner Signature _____ Signed at (city/state) _____

Proposed Insured Name (Please print) _____ Date _____

X Proposed Insured Signature (if other than the Proposed Owner) _____ Signed at (city/state) _____

Proposed Other Insured Name (Please print) _____ Date _____

X Proposed Other Insured Signature _____ Signed at (city/state) _____

X Writing Agent Signature _____ Date _____

Writing Agent Name (Please print) _____ Agent Phone # _____

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization is HIPAA compliant.

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(please print)* _____

Date of Birth _____ SSN/ITIN _____

Proposed Insured/Patient Address _____

AUTHORIZATION INFORMATION

This will authorize:

_____ *(Physician, Clinic or Hospital Name)*

to release medical information to _____ *(the Life Insurance Agent/Agency).*

Authorized Life Insurance Carrier(s) _____

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, according to the terms of this authorization. This includes any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Insurance Agent/Agency named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Insurance Agent/Agency may provide the information to the listed carrier(s) so that they may: 1) underwrite

my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Insurance Agent/Agency.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Insurance Agent/Agency named above at the following address.

Attention: Privacy Official

Agency Address _____

City _____ State _____ ZIP _____

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Proposed Insured/Patient or
Personal Representative Signature _____ Date _____

Description of Personal Representative's
Authority or Relationship to Patient *(please print)* _____

A copy of this Authorization must be given to the Proposed Insured.

CONSUMER PRIVACY NOTICE

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. 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. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. 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, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. 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 ReliaStar Life Insurance Company (the "Company"). You may request that this information not be communicated to other companies affiliated with the Company.

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; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

Notice Regarding MIB (Medical Information Bureau, Inc.)

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is 866-692-6901 and fax is 866-346-3642.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Notice Regarding Information Practices

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

This page must be given to the Proposed Insured and/or Owner.

VALUABLE INFORMATION ABOUT YOUR TERM LIFE INSURANCE PURCHASE

ReliaStar Life Insurance Company, Minneapolis, MN
Security Life of Denver Insurance Company, Denver, CO



Thank you for considering ReliaStar Life Insurance Company or Security Life of Denver Insurance Company (the "Company") for your life insurance needs. We offer various life insurance products that have different features, benefits and costs. Your professional insurance agent may work with many life insurance companies, and we are pleased that your agent has presented one of our products to you.

We'd like you to understand how we pay the selling agent. Agents earn a commission for each Company policy sold. The commission is generally a percentage of the policy premiums you pay. The percentage may be higher for agents that sell a larger number of Company policies. Agents may receive additional compensation for each year a policy remains in force or for achieving certain sales volume levels. The actual percentage and amount of compensation paid will vary based on the specific circumstances of your purchase.

Agents may receive additional non-cash compensation from us as a reward for things like achieving sales contest objectives or other measures. We also may pay for agent education, training or attendance at conventions, and may provide financing, or other payments or benefits. In addition, some agents may be associated with independent marketing organizations ("IMOs") that have agreements with us. IMOs provide administrative services to independent agents and marketing support for our policies. The Company may make payments to IMOs that may be based on the amount of premium written with the Company by agents associated with the IMO.

This is a general discussion of the compensation we pay for the sale of our policies. We pay commissions and other sales expenses from our general assets and revenues, including amounts we earn from fees and charges under our policies. The price of an insurance policy is set by the Company and reflects the compensation we pay for the sale of the policies. It also covers costs we incur for the design, manufacture and service of our policies, for policy benefits and features including guarantees, and for the investment management needed to support the policies' values. We are committed to providing top-quality insurance products to our customers and are pleased that your professional insurance agent trusts us to deliver on your long-term insurance needs.

This notice must be given to the Proposed Insured/Owner.

CREDIT CARD PAYMENT AUTHORIZATION AND ELECTRONIC FUNDS TRANSFER

ReliaStar Life Insurance Company, Minneapolis, MN
"the Company"

A member of the ING family of companies

ING Customer Service Center, PO Box 5052, Minot, ND 58702-5052

A. CREDIT CARD PAYMENT AUTHORIZATION

This service is not available in Alaska, California, Maryland, New Jersey, New York and North Carolina.

Request and Authorization for Credit Card Payment of Initial Premium: The Company is hereby requested and authorized to initiate a credit card transaction to be charged against the account described in the Authorization below for the **initial payment only**. Subsequent premium payments will be made either by direct billing or EFT.

Insured Name (Please print.)	Policy #	Payment Amount

Premium Payment Mode: Monthly Quarterly Semi-Annual Annual

Full Name (Print as it appears on card.) _____

Account # _____ Expiration Date (month and year) _____
(16 digits)

Credit Card Type: MasterCard Visa Discover Billing Zip Code _____

I authorize the Company to charge my initial insurance premium for the policy numbers listed above, to the credit card account I have indicated. I understand that this payment will be for the initial premium only, and that I will either be billed for subsequent payments directly or by EFT if I have indicated so on previous pages of this application.

Signature of Cardholder¹ _____

B. ELECTRONIC FUNDS TRANSFER

What is the EFT plan?

The EFT plan allows us to pay your policy premiums by automatically withdrawing funds from your financial institution's account. You will receive a notice that premium is due and a receipt for the amount withdrawn.

What happens if my financial institution does not honor a withdrawal?

If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. Premium payments are necessary to fund your policy; therefore, you will be required to send us a replacement payment. If we do not receive a replacement payment within the time required by your specific policy, your policy will enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage. To help prevent this, we encourage you to obtain overdraft protection from your bank.

Will the deductions always be for an equal amount?

Your premium payments will always be for the same amount. If you make any changes to your policy, including conversions or renewals, your premium payments may increase. We will notify you in advance of any withdrawals or premium increases.

How can I cancel the EFT plan?

To cancel, you must provide notice to us in writing. Once we receive your request, we will stop the plan within 7 – 10 business days. We may also terminate the EFT plan without notice if any withdrawal is not honored or 30 days after we provide written notice to the policy owner.

If the plan is cancelled, you must pay any unpaid and future premiums directly to us on the premium due date. Termination of the EFT plan does not change the premium due dates.

I'd like to enroll. Where do I sign?

Please read the following agreement and sign and date this form.

Authorization Agreement for Prearranged Payments

I authorize the Company to withdraw funds from my checking or savings account, identified on the next page, to pay premiums on my life insurance policy. This authorization will remain in effect until the Company has received a written request from me to terminate this agreement.

¹Payment cannot be processed without signature.

B. ELECTRONIC FUNDS TRANSFER (EFT) (CONTINUED)

Please Note: Premiums paid more frequently than annually result in higher total premiums for the same coverage.

This agreement authorizes: A new transfer A change in existing transfer amount A change in financial institution

Payment Frequency: Monthly Quarterly Semi-Annual Annual

Insured Name (Please print.)	Policy #	Deduction

Request Specific Draft Date _____

Bank Name _____

Bank Address _____

City _____ State _____ ZIP _____

Account type: Checking Savings Name(s) on Account _____

For checking accounts, please tape a voided check in the space below. For savings accounts, please tape a deposit slip. If you cannot provide these, you may write the bank routing number and account number in the appropriate fields.

Tape voided check or deposit slip here.

Routing Number _____ Account # _____
(9 digits)

Account Owner Signature _____ Date _____

SSN/TIN _____ Phone # _____



ING Service Center
2000 21st Avenue, NW
Minot, ND 58703

- ReliaStar Life Insurance Company
- Security Life of Denver Insurance Company

Consent to Blood (and Other Body Fluids) Testing Disclosure Authorization

I give my consent to the above named insurer, its employees, contractors, affiliated companies and reinsurers, to conduct the following:

- (1) Blood (and/or other body fluids) test for antibodies to the AIDS virus (HIV); if I reside in a state which permits insurers to conduct this test; and
- (2) Such other or additional tests which the company may lawfully order.

My consent to this testing is freely given, based on the following understandings:

- (1) The purpose of the test(s) is to determine whether I am insurable for life insurance.
- (2) I know I have the absolute right to refuse to take the test(s). I know I can exercise this right by telling the examiner I do not want to have my blood (and/or other body fluids) tested and by refusing to give sample(s). I know that if I do not take the test(s), my application to the company for life insurance will be declined.
- (3) The test(s) for the antibodies to the AIDS virus (HIV) will be conducted following approved test protocols.
- (4) If state law permits, I will be notified of positive HIV test results. Otherwise, I will be asked to designate, in writing, the name and address of the physician to whom I want the test results sent. I understand that in some states positive results may only be disclosed to the physician I designate to receive the results.

I further understand that test results will not be released or disclosed to any party (other than the company and related parties identified above, to whom I hereby authorize disclosure) unless:

- (a) I expressly authorize their release in writing; or
- (b) A public health reporting law requires disclosure; or
- (c) A court order requires disclosure.

I understand that disclosures under 4(b) and 4(c) may be made without my consent.

- (5) I understand that the company may report to the Medical Information Bureau (MIB) any abnormal blood (and/or other body fluids) test, but the company will not disclose the type of blood (and/or other body fluids) test which was abnormal. I acknowledge receipt of the company's Notice Regarding the MIB, Inc.

I know that I have the right to get a copy of this form. I agree that the authorization to disclose information set forth above shall be valid for 24 months from the date shown below.

I HAVE READ AND UNDERSTAND THIS CONSENT TO TESTING AND DISCLOSURE AUTHORIZATION.

Name of Proposed Insured

Signature of Proposed Insured

State of Residence of Proposed Insured

Date

Name of Examiner

Signature of Examiner



ReliaStar Life Insurance Company
Home Office: Minneapolis, MN
Administrative Office:
P.O. Box 5075
Minot, ND 58702-5075

LIVING BENEFIT RIDER DISCLOSURE STATEMENT

The accelerated benefit rider, better known as ReliaStar's Living Benefit Rider, allows the owner to access a portion of the life insurance death benefit if the insured becomes terminally ill (life expectancy of 6 months or less as determined by a physician). The benefit is always payable to the owner.

There is no additional premium required to issue this rider. If you request an accelerated benefit, an interest charge and an administrative expense charge will be deducted from the amount you request.

When an accelerated benefit is paid, the death benefit, cash values and loan values of the policy will be reduced proportionally. The amount will be determined at the time you request a Living Benefit payment.

For example, suppose you purchase a policy with a \$100,000 death benefit. Later, you request a Living Benefit payment of \$25,000. Any charges noted above would be deducted from the \$25,000 and the resulting total would be your Living Benefit payment. The death benefit on your policy would then be reduced to \$75,000, and any required premium would be reduced proportionally. If your policy has cash values, those accumulations would also be reduced proportionally.

Limitations of the Accelerated Benefit:

- (a) The rider is not intended to replace health or disability coverage. Rather, it provides an added source of funds to meet critical needs during a difficult time. You choose how the funds will best meet your needs. There are no restrictions on how a Living Benefit payment can be used.
- (b) Accelerated benefits payable under this rider may or may not be taxable. You should consult your personal tax advisor.
- (c) Receipt of accelerated benefits under this product may affect medicaid and supplemental security income ("SSI") eligibility.

If at some future point in time, you decide that you no longer wish to carry the Living Benefit Rider on your coverage, you may request that it be removed. The Living Benefit Rider will automatically terminate when the life insurance policy matures.

The Living Benefit Rider is subject to eligibility requirements.

**IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**



This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

(Refer to mailing address on application)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy or an annuity contract involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract or meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? Yes No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? Yes No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy Number	Insured or Annuitant	Replaced (R) or Financing (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant Name *(please print)* _____

Applicant Signature _____ Date _____

Producer Name *(please print)* _____

Producer's Signature _____ Date _____

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

1st Copy: Applicant

2nd Copy: Insurer

3rd Copy: Producer

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement of financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

OUT-OF-STATE VERIFICATION

- ReliaStar Life Insurance Company, Minneapolis, MN
 ReliaStar Life Insurance Company of New York, Woodbury, NY
 Security Life of Denver Insurance Company, Denver, CO

A member of the ING family of companies

ING Customer Service Center: 2000 21st Ave. NW, Minot, ND 58703



INSTRUCTIONS AND DEFINITIONS

This form must be completed and submitted with an application any time the application is signed in a state other than the owner/applicant's Residence State. Without this form, the application will not be accepted for review.

"Residence State" is the state where an individual owner/applicant has his or her primary residence and receives mail on a regular basis. A primary residence cannot be a temporary residence such as a time share, vacation rental or vacation home. Where the owner/applicant is a business entity, **"Residence State"** means the state where the business entity has its principal place of business or place of incorporation. For trusts, **"Residence State"** means the state where the trust is located or where the trustee has an office or residence.

"Application State" is the state where the owner/applicant signs the application and where the policy is solicited and delivered. The Application State must be a state where the agent and the applicable Insurer listed above are licensed and the product is approved.

APPLICATION INFORMATION

Application Date _____ Application State _____

Owner/Applicant _____

Owner/Applicant Residence Address _____

City _____ State _____ ZIP _____

File Code/List Bill Number _____ Employer Name _____

Employer Address _____

City _____ State _____ ZIP _____

ACKNOWLEDGEMENTS

In connection with the above referenced application, the undersigned acknowledge and affirm:

1. All communications, solicitation and negotiation of the application occurred in the Application State.
2. The application was signed by the owner/applicant and the agent in the Application State.
3. The owner/applicant will take delivery of the policy issued as a result of the application in the Application State.
4. The applicable Insurer will rely on this verification in issuing a policy under the application.

I acknowledge and affirm that the solicitation for this insurance and the signing of the application took place in the Application State and that the laws of the Application State will govern all legal rights and obligations under the policy applied for. If I am signing in a representative capacity, I warrant that I have the authority to bind the entity on whose behalf this document is being executed.

Owner/Applicant Signature _____ Date _____

Title (if the owner/applicant is an entity) _____

Entity Name (if the owner/applicant is an entity) _____

Agent Signature _____ Date _____

SUPPLEMENT TO APPLICATION
FOREIGN TRAVEL AND RESIDENCE QUESTIONNAIRE

- ReliaStar Life Insurance Company, Minneapolis, MN
- Security Life of Denver Insurance Company, Denver, CO
- For Policyowner Service Use Only:**
- ING USA Annuity and Life Insurance Company, Des Moines, IA
- Midwestern United Life Insurance Company, Fort Wayne, IN

Administrative Office
for all Companies:
ING Service Center
2000 21st Ave. NW
Minot, ND 58703

Name of Proposed Insured _____ Date of Birth _____

1. Country of Origin* _____ Current Citizenship _____

2. Date of entry into the United States _____

3. Visa type, symbol, number, and expiration date _____

4. Do you intend to remain permanently in the USA? Yes No

5. List immediate family members by relationship, age, and citizenship

Within the USA _____

Outside the USA _____

6. List your assets/property both within and outside the USA _____

7. Do you plan to travel or reside outside the USA?..... Yes No

If "Yes", provide details for each country to include specific locations, departure dates, duration and purpose of each stay

I have read the above questions and answers. I affirm that they are complete and true to the best of my knowledge and belief. I agree that this questionnaire is a part of my application for life insurance.

Signature of Applicant _____ Date _____

Signature of Proposed Primary Insured (if other than applicant) _____ Date _____

Agent's Signature _____ Date _____

* Do not answer if you are a resident of California.

NOTICE:

For Applicants in all States except for Colorado, District of Columbia, Florida, Kentucky, Louisiana, New Jersey, New Mexico, Ohio, Pennsylvania, Tennessee and Virginia.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files an application, statement or claim containing false, incomplete or misleading information may be guilty of insurance fraud.

THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THESE NOTICES:

COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or its agent who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA:

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA :

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY AND OHIO:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

LOUISIANA:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

PENNSYLVANIA:

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim 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 subjects such person to criminal and civil penalties.

TENNESSEE:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA:

Any person who with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application, statement or files a claim containing false, or deceptive statement may have violated the law.