



The Insurance & Benefits Trust of PORAC

Simple, Affordable & SAFE!

**Group Term Life Insurance
Application**
(10-Year Level Term Rate)

Monthly Premium Rates for 10-Year Group Level Term Insurance*

Monthly premium for \$250,000 in coverage

Issue Age	Non-Tobacco User	Tobacco User
18-26	11.50	24.34
27	11.50	24.83
28	11.50	25.64
29	11.50	26.72
30	11.50	29.43
31	11.50	31.04
32	11.50	32.96
33	11.50	35.15
34	11.50	37.58
35	11.50	40.31
36	11.75	43.26
37	12.00	46.48
38	12.75	50.05
39	13.25	53.93

Monthly premium for \$150,000 in coverage

Issue Age	Non-Tobacco User	Tobacco User
40	8.70	34.91
41	9.45	37.73
42	10.50	40.77
43	11.70	44.00
44	12.90	47.33
45	14.25	50.67
46	15.60	54.02
47	16.95	57.48
48	18.30	61.20
49	19.95	65.36

Monthly premium for \$100,000 in coverage

Issue Age	Non-Tobacco User	Tobacco User
50	14.70	46.64
51	16.20	49.99
52	18.00	53.58
53	19.90	57.48
54	22.20	61.75
55	24.50	66.22
56	26.80	70.69
57	29.30	75.41
58	32.10	80.94
59	35.30	87.85

**The initial premium may not change for the first 10 years; however the insurance company reserves the right to change the premium rates but only if rates are changed for all insureds under the group policy and with 60 days written notice. Policy form LP00GP*

Group Term Life Application for 10-Year Level Term Rate

Reference to Spouse includes Spouse or Domestic Partner

Please use this application to apply for Simplified Issue Insurance coverage during the specified enrollment period. If approved, your life coverage under this group policy will enter a 10-year level term rate period.

Please print clearly (black ink): Fax, Mail or Scan and e-Mail to:

Myers-Stevens & Toohey Co. | 26101 Marguerite Parkway | Mission Viejo | CA 92692
phone 800.827.4695 | fax 949.348.2630 | PORAC@myers-stevens.com | license #0425842

Insurance & Benefits Trust of PORAC (Policy 66326-3)

Tell us about yourself:

Are you a member of **PORAC**? Yes No

Your Name (last, first, middle)		<input type="checkbox"/> Female <input type="checkbox"/> Male	
Date of Birth / /	Social Security		
Department Name	Address		
City	State	ZIP	
E-mail Address	Home Phone	Work Phone	

1. Amount of coverage applied for during this enrollment period:

Under Age 40 - \$250,000 Age 40 - 49 - \$150,000 Age 50 - 59 - \$100,000

2. Matching Accidental Death coverage (Member)

Under Age 40 - \$250,000: \$10 per month
 Age 40 - 49 - \$150,000: \$6 per month
 Age 50 - 59 - \$100,000: \$4 per month

3. Check box to purchase: \$10,000 Dependent Family Insurance - \$1.80 per month

4. Have you used tobacco products of any kind in the last 12 months? Yes No

5. Are you currently working at least 24 hours per week at your regular occupation and place of business?

If no, please explain: Yes No _____

6. Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? If yes, please explain:

Yes No _____

Beneficiary Information:

List one or more beneficiaries below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent coverage will be the certificate holder.

Name	Address	Relationship	Percent

Provide us with this health information:

1. During the past 10 years have you consulted a doctor or health practitioner, taken medication or had treatment for any of the following:

- Yes No A. Cancer, tumors, stroke, connective tissue disease, diabetes, rheumatoid arthritis, Acquired Immune Deficiency Syndrome (AIDS), severe injury, organ transplant
- Yes No B. Disease or disorder of the heart, brain, liver, kidney, blood or lung (excluding asthma requiring oral steroid use)
- Yes No C. Other disease or disorder of the immune, neurological, digestive, urinary, circulatory (excluding controlled high blood pressure) or respiratory system
- Yes No D. Major or manic depression, psychosis, suicide attempt, use of alcohol, drugs or narcotics?

Condition/Illness/Treatments	Date(s) of Treatment	Physician Name/Mailing Address

2. In the past 5 years, have you had surgery, been confined or treated in a hospital or similar facility due to serious illness, or been advised to receive medical attention for any symptom(s) or condition?

Yes No

Condition/Illness/Treatments	Date(s) of Treatment	Physician Name/Mailing Address

Read this information carefully:

1. To the best of my knowledge and belief, the information I've provided is complete and correct.
2. 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.
3. I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization & Acknowledgment – Please Read & Sign Below:

For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, 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 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 to get consumer or investigative consumer reports about the 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 it's 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 it's 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 have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who knowingly and with intent to defraud, submits an application or files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

Signature	Print Name	Date

GTLEVELSI06-CA

ReliaStar Life Insurance Company | Box 20 | Minneapolis, MN 55440

The administrative information below is not part of the insurance application. Please complete and return. Do not detach from the application.

As a member in good standing of the Peace Officers Research Association of California, I hereby request to participate in the Life insurance plan sponsored by the Insurance & Benefits Trust of PORAC and underwritten by ReliaStar Life Insurance Company. I agree that premiums for this insurance shall be paid by payroll deduction, if available; otherwise, as billed by Myers-Stevens & Toohey & Co., Inc. If payroll deduction is not available, I prefer to be billed directly and pay my premiums: (check appropriate box)

Quarterly

Semi-Annually

Annually

Upon completion, Fax, Mail or Scan and e-Mail to:

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