ReliaStar Life Insurance Company	Accident Insurance Application
 Home Office: PO Box 20, Minneapolis, MN 55440 *Administrative Office:* PO Box 122, Minneapolis, MN 55440-0122	Type of Enrollment / Change: *(check all that apply)* ___ Initial Enrollment ___ Increase ___ Late Entrant** ___ Termination _x_ Regular Enrollee* (New Hire) ___ Decrease ___ Other_____ Regular Enrollee* A regular enrollee is a new employee / member enrolling in the plan at the first available opportunity. Late Entrant** A late entrant is an individual who is enrolling into the plan after the first available opportunity. ***Late entrants may be required to provide evidence of insurability.***

Section 1. Basic Information

Name of Group Policyholder	Group Number *(HO use only)*	Certificate Number *(HO use only)*
Dunn County	64620-2	

Section 2. Employee / Member Information

Employee / Member Name *(first, middle initial, last)*	☐ Female ☐ Male	Date of Birth ____/____/____ *(Month, Day, Year)*
Employee / Member Home Address *(street address, city, state, ZIP)*		Phone Number Work ( ) _____ Home ( ) _____

Department #	Location #	Pay Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other:_____	Employee / Member ID #
_____	_____		_____

Job Title or Occupation	Employee/Member Class	Basic Monthly Salary	Date of Hire	Social Security #
		$	____/____/____ *(Month, Day, Year)*	_____-_____-_____

Employment Status: I am Actively At Work ☐ Yes ☐ No I Am Scheduled to Work 32+ Hours Per Week	Accidental Death Beneficiary (Print First, Middle, Last)	Relationship to Employee/Member

Section 3. Riders

Benefit Elections:	Premium
Accident Insurance ☒ Employee/Member ☐ Spouse ☐ Child(ren)	$
☐ Off Job Accident Disability Income Rider Employee/Member Maximum Monthly Benefit Amount $_____ Increase/Decrease Monthly Benefit Amount From $_____ to $_____	$ N/A
Sickness Hospital Confinement Rider ☐ Employee/Member ☐ Spouse* ☐ Child(ren)*	$ N/A
Total Premium	$

*Spouse and/or child(ren) must apply for Accident Insurance before applying for Sickness Hospital Confinement Rider.

Section 4. Dependents (Complete only if applying for spouse and/or child(ren)'s coverage.)

Spouse Name (first, middle, last)	☐ Female ☐ Male	Date of Birth ____/____/____ (Month, Day, Year)
Child(ren)'s Name (first, middle, last)	Age	Date of Birth ____/____/____ *(Month, Day, Year)*
1.		
2.		
3.		
4.		
5.		
6.		

Section 5. Underwriting (Complete only if you are applying for Sickness Hospital Confinement Rider)

	Employee/Member (Applicant)	Spouse
1.) Are you or any family member applying for coverage currently pregnant?	☐ Yes ☐ No	
2.) Have you or your spouse ever been diagnosed or treated by a physician or other health care professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or AIDS related conditions? **You do not need to reveal any HIV or generic test results.**	☐ Yes ☐ No	☐ Yes ☐ No
3.) Within the past 12 months, have you or your spouse received medical advice or sought treatment for insulin-dependent diabetes, any disease or abnormality of the heart, stroke or liver disease including chronic hepatitis or been treated with 3 or more medications at the same time?	☐ Yes ☐ No	☐ Yes ☐ No
4.) Within the past 12 months, have you or your spouse received medical advice or sought treatment for cancer of any type including leukemia, Hodgkin's disease, melanoma (other than basal cell or squamous cell carcinoma of the skin), malignant tumors of any kind?	☐ Yes ☐ No	☐ Yes ☐ No

Remarks or Special Requests:

FRAUD WARNING STATEMENT

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 may have violated the state law.

Accident Insurance benefits are contingent on proof of loss. Benefits may require medical information from your health care provider.

ReliaStar Life Insurance Company reserves the right to withdraw the plan if participation during the initial enrollment is less than [25] covered Certificateholders or any other state specific participation requirements.

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my insurance coverage purchased through the *ReliaStar Life Insurance Company*. This authorization and assignment will remain in effect until revoked by me in writing to my Employer.

Read the section above and then sign and date below.

Proposed Effective Date of Certificate OR Date of Change: _____ – _____ – _____ *(Month, Day, Year)*

Provided you are actively at work, the actual Certificate Effective Date will be determined by the latest of the following:

(i) the date the completed application is submitted to and accepted by ReliaStar Life Insurance Company;

(ii) the date satisfactory evidence of insurability is received, if required;

(iii) the date the premium payment has been received.

Amendments, Corrections, and Notations (HO Use Only):

Employee / Member Signature:	Signed at *(City & State)*:	On *(Month, Day, Year)*:
Agent Signature:	Signed at *(City & State)*:	On *(Month, Day, Year)*:

☐ I decline coverage _____ Date_____