

# Affinity® Yearly Renewable Term Life Application

**STUDENT OFFER**

Please use this form to apply for Simplified Issue coverage during the specified enrollment period. The proposed insured should complete the application. *Please print clearly in dark ink and mail in the envelope provided.* **Affinity 2000**

**1**

## Tell us about yourself.

Name of Association:

YOUR NAME <i>(last, first, middle)</i>		DATE OF BIRTH <i>(month, day, year)</i>		<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE
STREET ADDRESS			CITY	STATE	ZIP
SOCIAL SECURITY NUMBER		HOME PHONE		WORK PHONE	

Owner (if other than yourself). *The owner controls all rights to the policy.*

NAME	ADDRESS
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- Are you currently working at least 30 hours per week at your regular occupation and place of business?  
 Yes     No
- Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities in force?  
 Yes     No
- Amount of coverage applied for during this enrollment period:  
 \$100,000 (under age 40)
- Optional coverage:  
 Children's Insurance Rider \$10,000 on each child

*If yes, please explain:* \_\_\_\_\_

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

**2**

## Provide us with this health information.

- Have you ever had or been treated for heart trouble, stroke, diabetes or cancer?     Yes     No
- Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV Virus?     Yes     No
- Have you ever sought help or received counseling or treatment for anxiety/ depression, alcohol or drug use, or are you currently using illegal drugs?     Yes     No

**3**

## Beneficiary information

List one or more beneficiaries below. Beneficiaries may include your spouse, children, parents, charities or anyone you wish. List the percent each will receive. The total must equal 100 percent.

NAME	ADDRESS	RELATIONSHIP	PERCENT

**4**

## Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life and the first premium is paid during my lifetime.
- I understand coverage begins on the "effective date" assigned by ReliaStar Life.

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

YOUR SIGNATURE	DATE SIGNED	SIGNATURE OF OWNER <i>(if other than yourself)</i>	DATE SIGNED
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<b>ADMINISTRATOR USE ONLY</b>	<input type="checkbox"/> New Member	Group Number	Ass'n. Name	Signature of Licensed Ins. Rep.
	<input type="checkbox"/> Current Member			
<b>HOME OFFICE USE ONLY</b>	Premium Amount \$	Effective Date	Policy Number	