Application Instructions

The FICPA Group Term Life Insurance Plan

1. Complete Application Form

Make sure to complete the form in its entirety. Incomplete applications will not be accepted. Illegible print may delay processing of application.

2. Complete Payment Method

Payment Option 1 - Monthly Auto Pay
If you elect to pay by Monthly Bank Draft (ACH), you do not need to send any premium. Upon approval of your application, we will automatically draft your account on a monthly basis. Make sure to complete the Authorization section and include a VOIDED check.

Payment Option 2 - Direct Annual Billing
If you elect the Direct Annual Billing method, upon approval of your application, you will receive an initial invoice for the amount of premium due to pay your coverage through the end of the plan year (to December 31st.) You will receive annual invoices thereafter, which will be due on January 1st.

3. Fax or Mail Forms To:

You may use this form as a FAX COVER

Fax to: (904) 396-2091

Your Name: ____________________________ Date: _______________
Attn: Application/Processing

Or Mail to:

Program Administrator
Member Benefits
7645 Gate Parkway, Suite 101
Jacksonville, FL 32256

Any questions? Call toll-free: 1-800-282-8626

Satisfaction guaranteed. You risk nothing by applying now.

If you are not completely satisfied when you receive your Certificate of Insurance, just notify us within 30 days and we'll refund any premium you've paid, provided no claims have been submitted or paid. No insurance will be in force, and you will be under no further obligation.

FICPA Member Group
Level Term Life Insurance Plan

- Competitive Member Group Rates
- Rates designed to remain level for 10 or 20 years*
- Underwritten by ReliaStar Life Insurance Company, a member of the Voya® Family of Companies, rated "A" (Excellent) by A.M. Best**

Apply now for affordable 10 or 20 Year level term life rates.
This is a Level Plan, so you lock in premiums based on your age when you apply. Your initial rate will not change during the level term, regardless of changes in your health, unless the insurance company exercises its right to change the premium rates for all insureds under the group policy and with 60 days written notice. This helps to make the plan a better value over time.

Eligibility for this plan.
Current members of FICPA, age 65 & under (age 55 & under for 20-year plan), who are actively working at least 30 hours per week, are eligible to apply for coverage.

Spouses and domestic partners may apply as well.
Your spouse or domestic partner is eligible to apply for coverage if you are a current member and your spouse is under age 66, able to conduct the normal activities of a person of like age and gender, and is in good health. Simply make a photocopy of the enclosed application or you can both apply on one application.

Save more if you qualify as "Super Preferred Non-Tobacco."
Non-tobacco users applying for $200,000 of coverage or higher and meeting the highest underwriting standards may qualify as "Super Preferred Non-Tobacco", the plan's best rates. Other non-tobacco users that are approved for coverage will qualify for "Preferred Non-Tobacco" rates.

A pay-out for terminal illness of up to $75,000.
If you are terminally ill and have a life expectancy of six months or less, you can receive a portion of your death benefit before dying. This is called the accelerated life benefit. You can receive a payment of 50 percent of your coverage, to a maximum of $75,000. All remaining insurance benefits will be paid to your beneficiary when you die. This accelerated payment could provide much needed financial relief during a terminal illness when extra funds are needed. The accelerated benefits may be taxable. You should consult a professional tax advisor for specific information.

Add Children's Life Insurance.
This coverage provides $10,000 of life insurance coverage for your dependent children. One premium covers all eligible unmarried dependent children, ages 6 months to 21 years, or to age 25 if a full-time student. Children ages 14 days to 6 months are eligible for $500 or $1,000.

Add Accidental Death & Dismemberment coverage.
The unexpected financial "shock" of an accident can be devastating to a family. That's why this offer includes an option to also purchase additional coverage for accidents, that pays your beneficiary an additional amount if you die in a covered accident. In addition, if you are dismembered or lose your sight in a covered accident, you will receive a portion of your coverage, depending on the accident's severity.

Continuing your coverage after the level term ends.
Coverage will not reduce during your level term period. At the end of your level term period, coverage will be converted to a group annual term plan, with premiums adjusted based on 5 year age bands, and you may keep the converted coverage through age 75. For members and spouses or domestic partners, who are under age 65 at the end of a level term period, coverage will not reduce until age 65. Coverage will reduce to 50% at age 65, to the lesser of 25% or 25,000 at age 70, and terminate at age 75.

For members and spouses or domestic partners, who are 65 to 70 at the end of a level term period, coverage will reduce to 50%, and thereafter to the lesser of 25% or 25,000 at age 70. For members and spouses or domestic partners, are age 70 to 75 at the end of a level term period, coverage will reduce to the lesser of 25% or 25,000, and terminate at age 75.

Plan carefully…

And minimize your family's financial security risks…no matter what tomorrow may hold in store. Designed for the specific needs of members of the FICPA.

How much coverage should you consider?

As a rule of thumb, many financial experts recommend life insurance equal to five to nine times your gross annual salary. Often, many people are "underinsured." It's important to maintain adequate levels of coverage to provide for your family's needs in the event of your unexpected death. It's prudent to review and update your life insurance periodically, as your financial responsibilities grow.

Through this plan, you and your spouse or domestic partner may apply for up to $1,000,000 of level term life coverage. Contact plan administrator if your coverage needs are greater than $1,000,000.

The Application Process.

Fully complete both sides of the enclosed application and return to the program administrator (address listed on the form). Providing complete and accurate information on your application can make the medical underwriting process quicker and easier.

All coverage is subject to underwriting approval by ReliaStar Life Insurance Company, and more medical information may be requested from you or from your attending physician(s). A physical exam, EKG, blood test or other information may also be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. This will be at no additional cost to you. Acceptance into the life plan is not guaranteed.

When coverage begins.

Your coverage will become effective on the first of the month following approval of your application by ReliaStar Life, and once your first premium payment is made.

Designate your beneficiary.

You may designate one or more beneficiaries on the application form. Attach a separate sheet if needed. You may request to change your beneficiary at any time by contacting the plan administrator.

No annual policy fee.

With this plan, you never pay an annual policy fee. You pay only the premiums you've qualified for.

Ownership transfer available.

The provisions of this group policy allow you to transfer ownership of coverage to your spouse, business partner, professional corporation or a trust. Transfer of ownership could result in a tax advantage for you. Contact your tax advisor for details.

Conversion.

If an insured later becomes ineligible for this group life insurance coverage, conversion to an individual whole life policy is allowed, without proof of good health. The conversion policy does not include accelerated benefits or AD&D.

Exclusions.

The only exclusion under this group term life policy is suicide within the first two years of coverage.

Program administrator.

For all inquiries, contact the FICPA Member Benefits Insurance Programs administrator: Member Benefits 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256. 1-800-282-8626. www.memberbenefits.com/ficpa

**Organization behind the coverage.

Insurance underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy Form LP08GP.ReliaStar Life Insurance Company is rated "A" (Excellent) by A.M. Best. This is third highest of 15 ratings. A.M. Best Company assigns ratings from A++ to F based on a company's financial strength and ability to meet obligations

Any questions? Call toll-free: 1-800-282-8626

30-day Free Look! Satisfaction is guaranteed. You risk nothing by applying now.

If you are not completely satisfied when you receive your Certificate of Insurance, just notify us within 30 days and we'll refund any premium you've paid, provided no claims have been submitted or paid. No insurance will be in force, and you will be under no further obligation.

This material is for summary purposes only. For a complete description of all benefits and exclusions, please read your Certificate of Insurance.

* To keep coverage in force, premiums are payable up to the date of policy or coverage termination. The initial premium will not change during the level term period, unless the insurance company exercises its right to change the premium rates for all insureds under the group policy and with 60 days written notice.
** ReliaStar Life Insurance Company is rated "A" (Excellent) by A.M. Best. This is third highest of 15 ratings. A.M. Best Company assigns ratings from A++ to F based on a company's financial strength and ability to meet obligations to contract holders.

Group Term Life Application for 10-Year or 20-Year Level Term Rate

Please complete the entire application. The proposed insured should fill out this application. *Please print clearly in dark ink and mail to **Member Benefits, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256. Phone 800-282-8626; Fax 904-396-2091***

Florida Institute of Certified Public Accountants	**Policy No. 31619-9**

1. TELL US ABOUT YOURSELF

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

Name (Last, First, M.I.) ❑ Association Member ❑ Employee of Member		Name of Member	Member #
❑ Male ❑ Female	Date of Birth (DD/MM/YYYY)	Place of Birth	Social Security Number
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

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

Name (Last, First, M.I.)		Name of Member	Member #
❑ Male ❑ Female	Date of Birth (DD/MM/YYYY)	Place of Birth	Social Security Number
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address	

Dependent Child(ren)'s Information ***(complete this section only if applying for Dependent Child(ren) on this application)*:**

Number of eligiblechildren:___________ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below

Name______________________________ DOB______________ SSN______________
Name______________________________ DOB______________ SSN______________
Name______________________________ DOB______________ SSN______________
Name______________________________ DOB______________ SSN______________

Address	City	State	Zip

	Member/Employee	Spouse
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?	❑ Yes ❑ No	❑ Yes ❑ No
Date of last use (month/year):	_____/_____	_____/_____
b) Are you currently working less than 30 hours per week at your regular occupation and place of business?	❑ Yes ❑ No	❑ Yes ❑ No
c) 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:____

2. SELECT YOUR COVERAGE

❑ 10-Year Level Term
❑ 20-Year Level Term

Member Amount

❑ Other: $__________ *in $5,000 increments*
(Minimum: $200,000 Maximum: $1,000,000)

❑ 10-Year Level Term
❑ 20-Year Level Term

Spouse of Member Amount

❑ Other: $__________ *in $5,000 increments*
(Minimum: $200,000 Maximum: $500,000)

❑ 10-Year Level Term
❑ 20-Year Level Term

Employee of Member Amount

❑ Other: $__________ *in $5,000 increments*
(Minimum: $200,000 Maximum: $500,000)

Please select if you wish to include additional options with your coverage *(If AD&D is elected, benefit will match life amount to a maximum of $600,000 for member, $500,000 for spouse and $250,000 for employee):*

❑ $10,000 Dependent Child(ren) Coverage*

❑ Member/Employee Accidental Death & Dismemberment

❑ Spouse of Member Accidental Death & Dismemberment

* If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION

Member/Employee: **Height______ft. _____in. Weight_______lbs.** Spouse of Member: **Height______ft. _____in. Weight_______lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member/Employee:____ Spouse of Member:____

____ ____

	Member/Employee	Spouse
1) Have you tested positive for exposure to the HIV infection or been diagnosed by a member of the medical profession as having AIDS or ARC caused by the HIV infection or other sickness or condition derived from such infection?	❑ Yes ❑ No	❑ Yes ❑ No
2) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack) , sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?................	❑ Yes ❑ No	❑ Yes ❑ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?................	❑ Yes ❑ No	❑ Yes ❑ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?................	❑ Yes ❑ No	❑ Yes ❑ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?..	❑ Yes ❑ No	❑ Yes ❑ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?..	❑ Yes ❑ No	❑ Yes ❑ No
3) 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
4) To the best of your knowledge, have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?	❑ Yes ❑ No	❑ Yes ❑ No
5) Have you in the last three years flown, or do you anticipate flying in an aircraft within the next two years, other than as a passenger on a scheduled airline?	❑ Yes ❑ No	❑ Yes ❑ No
6) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?	❑ Yes ❑ No	❑ Yes ❑ No

a. Member/Employee's driver's license number and state of issue:________________________________

b. Spouse of Member's driver's license number and state of issue:________________________________

	Member/Employee	Spouse
7) Have you ever applied for insurance that was declined, postponed or modified in any way?.............	❑ Yes ❑ No	❑ Yes ❑ No
8) Do you currently have any disorder, condition or disease diagnosed or treated by a member of the medical profession, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?	❑ Yes ❑ No	❑ Yes ❑ No

For every "Yes" answer to questions in the previous section, give details below. Exclude any additional information regarding treatment for HIV/AIDS/ARC. 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/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				
	❑ Member/Employee ❑ Spouse of Member				

PLEASE COMPLETE AND SIGN END OF APPLICATION

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Member/Employee Coverage ***(complete this section only if applying for Member/Employee coverage on this application)***

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Beneficiary for Spouse of Member Coverage ***(complete this section only if applying for Spouse of Member coverage on this application)***

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

Name (Last, First, M.I.)			
Date of Birth (DD/MM/YYYY)	Social Security Number	Relationship	Percent
Address	City	State	Zip

5. SELECT PAYMENT METHOD

***(Choose only one. Option selected is applicable to all coverages approved through this application)*:**

☐ **Monthly Auto-Pay. I have included a VOID check and completed the Authorization below.**

Upon approval of my application by ReliaStar Life, I hereby authorize Member Benefits to initiate debit and credit entries to my Checking account and the Financial Institution named below to debit and/or credit the same account. Member Benefits will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid within the payment Grace Period. I acknowledge that the origination of ACH transactions to m y account must comply with the provisions of U.S. law. Service fees, when applicable by law, may apply for ACH debit returns, Member Benefits and my Bank may discontinue this service. This authority is to remain in full force and effective until Member Benefits has received written notice from me of its termination in such time and manner as to afford Member Benefits and the Financial Institution a reasonable opportunity to act on it.

X______________________________________ ____/____/________ ____

Accountholder's Signature Date Name of Financial Institution

☐ **Annual Direct Bill. Send No Money Now!**

If you select this method, and are approved for coverage, you will receive an initial invoice along with your certificate of insurance, for the required premium to pay your coverage through the end of the group plan year (Dec. 31st). After you pay your initial invoice, you will be invoiced for your full annual premium due January 1st each group plan year.

PLEASE COMPLETE AND SIGN END OF APPLICATION

6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- 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 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 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.

Member/Employee's Signature	Date	Spouse of Member's Signature (if applying)	Date

Privacy Notice

FACTS	WHAT DOES VOYA FINANCIAL DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number and account balance • Assets and transaction or loss history • Investment experience and employment information
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Voya chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Voya share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	No	We don't share

To limit our sharing	• Call our toll-free number (855) 685-9519 – our menu will prompt you through your choice(s) **Please note:** If you are a *new* customer, we can begin sharing your information 30 days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.

Questions?	Call the telephone number listed on your statements and other correspondence or go to http://voya.com/contact-us

Privacy Notice

Who we are	
Who is providing this notice?	This notice is provided by certain companies owned by Voya Financial, Inc. A list of these companies is provided at the end of this notice.

What do we do	
How does Voya protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Voya collect my personal information?	We collect your personal information, for example, when you • open an account or give us your contact information • apply for insurance or seek advice about your investments • tell us about your investment or retirement portfolio We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only • sharing for affiliates' everyday business purposes – information about your creditworthiness • affiliates from using your information to market to you • sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your account.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our affiliates include companies with the Voya name; financial companies such as Voya Retirement Insurance and Annuity Company; and nonfinancial companies such as Voya Services Company.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Voya does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Voya does not jointly market.

Other important information
We will comply with more restrictive state laws to the extent that they apply. If you live in an "opt-in" state such as California or Vermont, we will obtain your affirmative consent to share your personal information with nonaffiliates who do not currently assist us in servicing your account or conducting our business. If you are a participant in a retirement plan sponsored by your current or former employer, we will not share your personal information to the extent prohibited by your plan sponsor.

Voya affiliates
This notice is provided by: Directed Services LLC; Midwestern United Life Insurance Company; ReliaStar Life Insurance Company; ReliaStar Life Insurance Company of New York; Security Life Assignment Corp.; Security Life of Denver Insurance Company; Voya America Equities, Inc.; Voya Capital Corporation, LLC; Voya Financial, Inc.; Voya Financial Partners, LLC; Voya funds; Voya Funds Services, LLC; Voya Institutional Plan Services, LLC; Voya Institutional Trust Company; Voya Insurance and Annuity Company; Voya Investments, LLC; Voya Investments Distributor, LLC; Voya Retirement Advisors, LLC; Voya Retirement Insurance and Annuity Company

Order #130328 05/01/2015