FAMB GROUP LEVEL TERM LIFE INSURANCE PLAN

ENROLLMENT INSTRUCTIONS:

1) COMPLETE GROUP LEVEL TERM LIFE APPLICATION FORM

2) COMPLETE PAYMENT METHOD FORM

Payment Option 1
If you elect to pay by Monthly Bank Draft (ACH), upon approval of your application, we will automatically start drafting your account on a monthly basis.

Payment Option 2
If you elect to be billed directly, upon approval of your application, we will send you an invoice.

3) MAIL OR FAX FORMS TO:

BPC Financial
7645 Gate Parkway
Suite 101
Jacksonville, FL 32256

Phone: (800) 282-8626
Fax: (904) 396-2091

4) IMPORTANT:

Your coverage will become effective on the 1st of the month following approval of your application. When you receive your Certificate of Coverage, review it carefully. Be sure you understand all of your rights and benefits under the plan. If you are not completely satisfied, for any reason, please notify us immediately.

If you have any questions, please call us toll free at **1-800-282-8626.**

Group Term Life Application for 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* ***BPC Financial, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256; Phone 800-282-8626; Fax 904-396-2091.***

1 Tell us about yourself

Name of Association

Florida Association of Mortgage Brokers	65398-5

Are you applying as: ☐ Association Member ☐ Spouse of Member ☐ Employee of Member

Your Name *(last, first, middle)*		☐ Female ☐ Male	Name of Member
Date of Birth	Height	Weight	Social Security number
Address			
City		State	ZIP
Home Phone	Work Phone	E-mail Address	

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

Name	Address	
City	State	ZIP

➤ Indicate amount of life insurance applied for. If you are currently insured under this Group Policy and are applying for entry into a 20 –year level term rate period, indicate your amount of total life coverage requested (include current and additional amount desired, if applicable). If approved, your total amount of life coverage under this group policy will enter a 20 –year level term rate period.

$ ____________________
in $5,000 increments

➤ Check box(es) to purchase:

☐ $________ Accidental Death & Dismemberment (indicate total amount of AD&D coverage requested under this Group Policy)

☐ $ 5,000 Dependent Child Insurance, or

☐ $10,000 Dependent Child Insurance

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

➤ 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 now in force? ☐ Yes ☐ No

If yes, please explain: ____________________

2 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

3 Provide us with this health information

a.) Have you, for any condition during the past 12 months, consulted a physician/health practitioner, received surgical or medical care, or taken prescribed medication? ☐ Yes ☐ No

b.) Have you ever been treated or diagnosed by a physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV? ☐ Yes ☐ No

c.) Have you ever been diagnosed with or been treated for: disease or disorder of heart; lungs; nervous/mental system (including anxiety and depression); liver; kidneys; stomach; colon or genito-urinary system; stroke; high blood pressure; cancer or tumor; diabetes; or arthritis? ☐ Yes ☐ No

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

Please complete and sign back of application.

d.) Have you ever sought help or received counseling or treatment for alcohol or drug use, or are you currently using illegal drugs? ☐ Yes ☐ No

e.) Has your mother, father, or any sister or brother died prior to age 70 as a result of heart disorder, stroke, or cancer? ☐ Yes ☐ No

f.) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline? ☐ Yes ☐ No

g.) Have you used tobacco or nicotine in any form in the last 5 years? ☐ Yes ☐ No

h.) Have you in the last three years had any motor vehicle accidents, DUI convictions (driving under the influence) or other moving violations? ☐ Yes ☐ No
Please provide your driver's license number: ______________________________

i.) Have you ever applied for insurance that was declined, postponed or modified in any way? ☐ Yes ☐ No

If you answered "yes" to any of the questions above, please give full details below. Attach additional sheets if needed.

Q#	Name	Conditions/illness/treatment	Date(s) of treatment	Physician/health practitioner's name and complete mailing address

j.) List the name and address of your regular physician/health practitioner and the date you last consulted him or her:

____

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 Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment – Please read and 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 and 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. 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.

Your Signature	Date Signed

Signature of Owner *(if other than yourself)*	Date Signed

PLEASE INDICATE YOUR PAYMENT METHOD

☐ I wish to use Monthly Auto-Pay. I have attached a VOID check and completed the Authorization below.

☐ Please bill me directly: (If you select this method, you must submit a check or money order for that amount)

☐ Annually ☐ Semi-Annually ☐ Quarterly

MONTHLY AUTO PAY AUTHORIZATION FORM

You may pay your insurance premiums monthly through monthly pre-authorized debit transactions (ACH) at no additional cost. If you would like to take advantage of this payment option, please complete the form below, attach a voided check, sign and return.

NAME: ______________________________

I hereby authorize BPC Financial initiate debit entries and to initiate, if necessary, credit entries as adjustments for any debit entries in error to my Checking account and the Financial Institution named below to debit and/or credit the same account. BPC Financial 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. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

FINANCIAL INSTITUTION: ______________________________

BRANCH: ______________________________

STREET ADDRESS: ______________________________

CITY: ____________________ ST: ________ ZIP: ______________

This authority is to remain in full force and effective until BPC Financial and The Financial Institution have received written notice from me of its termination in such time and manner as to afford BPC Financial and The Financial Institution a reasonable opportunity to act on it.

SIGNATURE: ______________________ DATE: ______________

ATTACH VOIDED CHECK BELOW

Attach a voided check here. All total costs will be drawn the 1st of the month.

NOTE: IF THE ACH DEBIT IS RETURNED FOR NONSUFFICIENT FUNDS. A $25 NONREFUNDABLE SERVICE FEE WILL BE APPLIED WHEN ALLOWED BY LAW.

Member Group Level Term Life Insurance Plan

Available to Members, Spouses, and Employees

The plan provides enrollees with term life insurance protection in the amount you select, from $200,000 to $600,000. This group coverage is available to you as a member of the FAMB, as well as to your spouse, and employees. Administrative costs for group coverage are low, so you can save in premium costs and enjoy the benefits of the plan.

Plan Features

Eligibility
FAMB members, spouses, and employees under age 65 who are actively at work are eligible for coverage. Your spouse is eligible to apply for coverage if you are an FAMB member (participating in the plan) and your spouse is able to conduct the normal activities of a person of like age and gender, and is in good health.

Spouse and Employee Coverage
Spouses can apply for coverage amounts of $200,000 to $600,000 in $5,000 increments, not to exceed the member's coverage amount. Employees can apply for coverage amounts of $200,000 to $600,000 not exceed the member's amount.

No Annual Policy Fee
With this plan, you never pay an annual policy fee.

Level Term for 10 or 20 Years
There are no investment structures, which can inflate the cost, and because it's a level plan, you lock premiums at your age when you apply. Your rate may not increase durng the level term period, regardless of changes in your health, however the insurance company reserves the right to change premium rates, but only if rates are changed for all insureds under the group policy and with 60 days written notice.

At the end of the level term period, evidence of insurability is required to enter another level term period (subject to the maximum age to begin a level term period). If evidence of insurability is not provided or not approved by Reliastar Life, rates will be based on the five-year age brackets for the insured's current age.

Continuous Coverage to Age 75
Your amount of insurance will not decrease due to age during a level term rate period. Your amount of insurance decreases to 50% on the Group Policy anniversary date on or after your 65th birthday. On the Group Policy anniversary date on or after your 70th birthday, your amount of insurance decreases to the lesser of 25% or $25,000. Insurance terminates on on the Group Policy anniversary date on or after your 75th birthday.

Coverage is subject to renewal by the Association Insurance Trust (with continued participation by the Florida Association of Mortgage Brokers) and timely premium payment.

Accelerated Life Benefit
If you are diagnosed with medical condition and have a life expectancy of six months or less, you may apply for an accelerated life benefit of up to 50% percent of your life benefit, up to $50,000. This payment could help you and your loved ones in a time

All remaining insurance benefits will be paid to your beneficiary when you die.

Conversion
If an insured later becomes ineligible for this group coverage, conversion to an individual whole life policy is allowed, without proof of good health. Accelerated life coverage is excluded from conversion.

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.

Optional Additional Benefits

Accidental Death and Dismemberment (AD&D)

The unexpected financial "shock" of an accident can be devastating to a family. That's why this plan offers a special accident safeguard. The accidental death and dismemberment benefit (AD&D) option pays your beneficiary the amount of coverage you select 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.

AD&D coverage will cost an additional $0.30 per month per $10,000 of coverage. To add, simply check the box on the application.

Children's Insurance Rider

This rider provides options of $5,000 or $10,000 of 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.

Children's coverage will cost an additional $.42 a month for $5,000 of coverage or $.83 a month for $10,000 of coverage. To add, simply check the box on the application.

Underwriting your application

Some applicants may be required to have a medical exam in order to apply for coverage. For more information of medical requirements, please consult the plan administrator.

Exclusions

The only death claims against your group term life insurance to be denied will be for misrepresentation on your application, or death by suicide within the first two years of coverage. Please read your insurance certificate for details. For information on termination of coverage, also consult your certificate.

Programs Administrator

For all inquiries, contact The FAMB Insurance & Retirement Programs administrator: BPC Financial, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256. 1-800-282-8626. www.MemberBenefits.com

The Organization Behind The Coverage

Your insurance is provided by Reliastar Life Insurance Company, rated "A+" (Superior) by A.M. Best, an independent insurance rating agency. This is the second of 15 rating categories ranging from A++ to F for operating performance and financial strength. Reliastar Life Insurance Company, Minneapolis, MN has Minnesota roots tracing back to 1885. Reliastar Life is a member of the ING family of companies and is a wholly owned indirect subsidiary of ING Groep N.V., an Amsterdam-based global leader in integrated financial services, providing banking, insurance and asset management businesses in over 50 countries worldwide.

This document is for summary purposes only. For a complete description of benefits and limitations, please read your Certificate of Insurance. Policy form LP08GP. Florida Licensed Agent: Earl C. Trefry, Jr. CLU

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. 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, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. 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 us. 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; or your state's Insurance Information and Privacy Protection Act, if any. 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. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.