



ILLINOIS STATE
BAR ASSOCIATION*

Group Term Life Simplified Issue Application for 10-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 **ISBA Group Insurance Program, P.O. Box 10374, Des Moines, IA 50306-8812, or call 1-800-503-9230, or email customerservice.service@mercer.com.**

Illinois State Bar Association

Policy No. 67941-1

1. TELL US ABOUT YOURSELF

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

Name (Last, First, M.I.)				<input type="checkbox"/> Male	
				<input type="checkbox"/> Female	
Date of Birth (MM/DD/YYYY)	Place of Birth		Social Security Number		
Address		City	State	Zip	
Home/Cell Phone #	Work Phone #	E-mail Address			

Spouse/Domestic Partner's Information (complete this section only if applying for Spouse/Domestic Partner coverage on this application):

Name (Last, First, M.I.)		Name of Member	<input type="checkbox"/> Spouse of Member		<input type="checkbox"/> Male	
			<input type="checkbox"/> Domestic Partner (DP) of Member		<input type="checkbox"/> Female	
Date of Birth (MM/DD/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 eligible children: _____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) to each child below					
Name	DOB	SSN			
Name	DOB	SSN			
Name	DOB	SSN			
Name	DOB	SSN			
Address		City	State	Zip	Home/Cell Phone #

Member Spouse/DP

- a.) Have you used tobacco or nicotine products of any kind in the last 12 months? Yes No Yes No
- 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

Member Amount:

\$150,000 (Under age 50) \$100,000 (Under age 55) \$50,000 (Under age 60)

Spouse/Domestic Partner Amount:

\$150,000 (Under age 50) \$100,000 (Under age 55) \$50,000 (Under age 60)

Please select if you wish to include additional options with your coverage:

\$5,000 Dependent Child(ren) Coverage*

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

3. PROVIDE YOUR HEALTH INFORMATION

Member: Height ___ ft. ___ in. Weight ___ lbs.

Spouse/DP: Height ___ ft. ___ in. Weight ___ lbs.

- | | <u>Member</u> | <u>Spouse/DP</u> |
|--|--|--|
| 1. Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been diagnosed or treated by a member of the medical profession for: | | |
| a.) stroke, cancer/tumor, diabetes, or a mental condition requiring hospitalization?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b.) disease or disorder of the heart, lungs (excluding asthma), liver or kidneys?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c.) disease or disorder of the blood, or neurological, immune, digestive or intestinal system?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. In the past 5 years, have you 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. In the past 5 years, have you been hospitalized or admitted to a medical care facility?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. In the past 24 months, have medical tests, procedures or treatment been recommended by a member of the medical profession that have not yet been performed?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For every "Yes" answer to questions in the previous section, give details below. 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
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse/DP				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse/DP				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse/DP				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse/DP				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse/DP				
	<input type="checkbox"/> Member <input type="checkbox"/> Spouse/DP				

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 Coverage (complete this section only if applying for Member coverage on this application)

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

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

Beneficiary for Spouse/Domestic Partner Coverage (complete this section only if applying for Spouse coverage on this application)

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

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

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

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

Option 1: AUTOMATIC CHECK WITHDRAWAL REQUEST: Monthly Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: _____ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

Option 2: DIRECT BILL: Quarterly Semi-Annual Annual

Billing dates will begin after coverage is approved and initial premium has been received.

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 with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Member's Signature (always required)	Date	Spouse/Domestic Partner's Signature (if applying)	Date
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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 MIB, LLC., formerly known as the Medical Information Bureau. See “Notice Regarding MIB, LLC.” below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

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, LLC, 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, LLC.

We or our reinsurers may make brief reports to MIB, LLC (hereafter “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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB’s phone number is 866-692-6901. 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.

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Domestic Partnership Declaration

Name of Applicant _____

Name of Domestic Partner _____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.
2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).
3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):
 - Common ownership of a motor vehicle.
 - Joint bank or credit accounts.
 - Assignment of durable power of attorney in favor of one another.
 - Common ownership of real estate or common leasehold interest in property.
 - Joint ownership or holding of stocks, bonds or other investments.
 - Execution of will naming each other as executor and/or beneficiary.
 - Designation as beneficiary under the other's retirement or pension benefits account.
4. That the undersigned member and domestic partner (check one):
 - have filed a domestic partner declaration with the (City/Council/Borough) of _____ and that such domestic partner declaration remains in effect (attach copy of declaration).
 - do not reside in a jurisdiction that provides for the registration of domestic partnership declarations.
5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.
6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.
7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability that would prevent them from making this affidavit.
8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.
9. That the undersigned member and domestic partner are not related by blood in any degree that would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature _____ **Date** _____

Soc. Sec. No. _____

Domestic Partner's Signature _____ **Date** _____

Soc. Sec. No. _____

Simplified Issue Group 10-Year Level Term Life Insurance Plan



ILLINOIS STATE
BAR ASSOCIATION®

FOR ISBA MEMBERS AND THEIR FAMILIES

- *Premiums designed to remain level for 10 Years**
- *Coverage for 10 Years*

Simplified Issue Group 10-Year Level Term Life Insurance is Coverage Your Family Needs

You certainly understand the importance of having sufficient life insurance. Now, you have an opportunity to make sure that you have the amount of coverage needed. Your loved ones will appreciate the peace of mind this Plan provides, with benefits up to \$150,000 that will let them go on with their lives with fewer financial concerns.

About This Plan

If you are under age 50, you may apply for up to \$150,000 in Simplified Issue 10-Year Group Level Term Life Insurance coverage without submitting a full medical exam or providing blood work. Coverage continues as long as you remain an active member of the ISBA, pay your premium when due, and the Group Policy remains in force. Your amount of coverage will not decrease due to age during a level term rate period.

For members or spouse/domestic partners who are under age 60 at the end of a level term period, coverage will not reduce until age 65. Coverage will reduce by 50% at age 65, 70 and 75. Coverage terminates on the group policy anniversary date on or after your 80th birthday.

Eligibility

All ISBA members under age 60 may apply for coverage for themselves, their spouse or domestic partner under age 60 and all unmarried, dependent children ages 14 days through 18 years (22 if full-time student). Members and spouses/domestic partners under age 50 are eligible to apply for up to \$150,000 in life benefits; members and spouses/domestic partners under age 55 are eligible to apply for up to \$100,000 in life benefits; and members under age 60 are eligible for up to \$50,000 in life benefits.

A spouse/domestic partner who is also a member is eligible for either member or spouse/domestic partner coverage, but not both. If both member and spouse/domestic partner are covered as members, neither may insure the other as spouse and only one may insure any eligible children. Coverage is not available in all states.

PLAN FEATURES

Satisfaction Guaranteed

You may return your Certificate of Insurance within 30 days if you are not completely satisfied with the coverage this Plan provides. Any premiums paid will be fully refunded, provided no claims have been submitted or paid.

Convenient Payment Options

You will automatically be billed on a semiannual basis. However, there are other payment options available. You can choose from quarterly direct billing, annual direct billing or automatic check withdrawal.

If you would like to change your payment method, please contact the program administrator at 1-800-503-9230.

Beneficiary Selection

You may name anyone you wish as your beneficiary. You may change the beneficiary by contacting the Insurance Administrator in writing and advising them of the change.

You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

Continuing Insurance After the 10-Year Term Ends

Premiums are designed to remain level for the first 10 years of coverage.* At the end of the 10-year period, if you still meet the requirements of eligibility, you may apply for re-entry. A written application and proof of good health satisfactory to the insurance company is required.

Or you can be automatically transferred to group annual term life coverage with attained age rates, without proof of good health, and subject to all terms and eligibility requirements of the group policy. The initial premium rate will be based on your current age at the time of transfer.

*The initial premium will not change for the first ten years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

Effective Date

Your insurance will become effective on the later of the following dates:

- The insurance company approves your proof of good health.
- Your premium is received.
- You become eligible for insurance.
- You apply for insurance, if proof of good health is not required.

When Coverage Ends

Your insurance stops on the earliest of the following dates:

- The last day of the month during which you are no longer eligible for insurance under the Group Policy.
- The Group Policy anniversary date on or after your 80th birthday
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.
- The date the Group Policy terminates.

Exclusions

You are covered 365 days a year, wherever you are. The only exclusion is suicide within the first two years of the date your insurance or increase in insurance starts. The Accelerated Life benefit is subject to additional exclusions.

Consider Your Eligibility

Before you apply for coverage, you must be a member in good standing of ISBA. You must be a member for 30 days before initiating your insurance requests.

OTHER IMPORTANT INFORMATION

Accelerated Life Benefit

The Accelerated Life Benefit is available to help terminally ill insureds during a difficult, and often financially challenging, time. Under this provision, you may request one advance payment up to 60% of in force life insurance, or \$250,000, whichever is less, to be paid while you are still alive. The amount of insurance payable after your death will be reduced by this payment. Premium contributions will not be reduced.

This money can be used for any purpose, such as: to help cover high prescription drug costs ... medical bills ... outstanding debts ... to help pay for experimental treatments ... the cost of modifications to your home ... or for a family vacation – the choice is yours. To qualify, you must provide the insurance company with a doctor's statement which gives the diagnosis of your medical condition and states you have a life expectancy of no more than 24 months. For additional details and limitations, please see the Certificate of Insurance.

Please note that receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.

Quarterly Premiums for \$50,000 Coverage

Issue Age	Male		Female	
	Tobacco	Non-Tobacco Preferred	Tobacco	Non-Tobacco Preferred
18-26	\$18.00	\$8.00	\$12.00	\$7.00
27	18.50	8.00	12.50	7.00
28	19.00	8.00	13.50	7.00
29	19.50	8.00	14.00	7.00
30	20.50	8.00	15.00	7.00
31	21.50	8.00	16.00	7.00
32	23.00	8.00	17.50	7.00
33	24.50	8.00	19.00	7.00
34	26.50	8.50	20.50	7.00
35	28.50	8.50	22.00	7.00
36	30.50	8.50	24.00	7.50
37	33.00	8.50	26.00	7.50
38	35.50	8.50	28.00	8.00
39	38.50	9.00	30.50	8.50
40	42.00	9.50	32.50	9.50
41	46.00	11.50	35.00	10.00
42	50.00	12.50	37.50	11.00
43	54.50	13.50	40.00	12.50
44	59.00	15.00	42.50	13.50
45	64.50	16.00	46.50	14.50
46	69.50	17.50	49.00	15.50
47	74.00	20.00	51.50	16.50
48	79.00	21.50	54.50	17.50
49	84.50	24.00	57.50	18.50
50	90.50	26.50	60.50	20.00
51	97.00	29.00	63.50	21.50
52	103.50	31.50	66.50	23.00
53	110.50	35.00	70.00	24.50
54	118.00	38.00	73.50	26.50
55	126.00	41.50	77.50	28.50
56	133.50	45.50	81.50	31.00
57	141.50	49.00	85.50	33.00
58	151.00	54.00	90.00	35.50
59	163.50	59.50	95.50	38.50

Quarterly Premiums for \$100,000 Coverage

Issue Age	Male		Female	
	Tobacco	Non-Tobacco Preferred	Tobacco	Non-Tobacco Preferred
18-26	\$36.00	\$16.00	\$24.00	\$14.00
27	37.00	16.00	25.00	14.00
28	38.00	16.00	27.00	14.00
29	39.00	16.00	28.00	14.00
30	41.00	16.00	30.00	14.00
31	43.00	16.00	32.00	14.00
32	46.00	16.00	35.00	14.00
33	49.00	16.00	38.00	14.00
34	53.00	17.00	41.00	14.00
35	57.00	17.00	44.00	14.00
36	61.00	17.00	48.00	15.00
37	66.00	17.00	52.00	15.00
38	71.00	17.00	56.00	16.00
39	77.00	18.00	61.00	17.00
40	84.00	19.00	65.00	19.00
41	92.00	23.00	70.00	20.00
42	100.00	25.00	75.00	22.00
43	109.00	27.00	80.00	25.00
44	118.00	30.00	85.00	27.00
45	129.00	32.00	93.00	29.00
46	139.00	35.00	98.00	31.00
47	148.00	40.00	103.00	33.00
48	158.00	43.00	109.00	35.00
49	169.00	48.00	115.00	37.00
50	181.00	53.00	121.00	40.00
51	194.00	58.00	127.00	43.00
52	207.00	63.00	133.00	46.00
53	221.00	70.00	140.00	49.00
54	236.00	76.00	147.00	53.00

Dependent Child(ren) Coverage: Quarterly for \$ 5,000 is \$2.49.

Rates shown are quarterly as of August 1, 2022.

If you are under age 50, you may apply for up to \$150,000 in coverage.

If you are under age 55, you may apply for up to \$100,000 of Simplified Issue Level Term Life Insurance. You can apply for up to \$50,000 of coverage between ages 55–59. Your rate for the entire term you select is designed to be the rate for your age at the time coverage is issued*.

*Premiums are based on your age at date of issue and will not increase due to your age or health status. Coverage will not be reduced during your level term period. The initial premium rates will not change for the first 10 years unless the insurance company exercises its right to change the premium rates for all insureds covered under the group policy with 60 days advance written notice. The level term rate period begins on the effective date assigned by ReliaStar Life Insurance Company.

The classes of rates are “Preferred” and “Tobacco.” Nontobacco users qualify for the higher “Preferred” rates. (Note: Tobacco users only qualify for “Tobacco” rates.) Upon approval of your application by the insurer, you will be notified of the rate classification for each approved person.

If applicable, an additional \$2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment method.

Quarterly Premiums for \$150,000 Coverage

Issue Age	Male		Female	
	Tobacco	Non-Tobacco Preferred	Tobacco	Non-Tobacco Preferred
18-26	\$54.00	\$24.00	\$36.00	\$21.00
27	55.50	24.00	37.50	21.00
28	57.00	24.00	40.50	21.00
29	58.50	24.00	42.00	21.00
30	61.50	24.00	45.00	21.00
31	64.50	24.00	48.00	21.00
32	69.00	24.00	52.50	21.00
33	73.50	24.00	57.00	21.00
34	79.50	25.50	61.50	21.00
35	85.50	25.50	66.00	21.00
36	91.50	25.50	72.00	22.50
37	99.00	25.50	78.00	22.50
38	106.50	25.50	84.00	24.00
39	115.50	27.00	91.50	25.50
40	126.00	28.50	97.50	28.50
41	138.00	34.50	105.00	30.00
42	150.00	37.50	112.50	33.00
43	163.50	40.50	120.00	37.50
44	177.00	45.00	127.50	40.50
45	193.50	48.00	139.50	43.50
46	208.50	52.50	147.00	46.50
47	222.00	60.00	154.50	49.50
48	237.00	64.50	163.50	52.50
49	253.50	72.00	172.50	55.50

Dependent Child(ren) Coverage: Quarterly for \$ 5,000 is \$2.49.

Rates shown are quarterly as of August 1, 2022.

If you are under age 50, you may apply for up to \$150,000 in coverage.

If you are under age 55, you may apply for up to \$100,000 of Simplified Issue Level Term Life Insurance. You can apply for up to \$50,000 of coverage between ages 55–59. Your rate for the entire term you select is designed to be the rate for your age at the time coverage is issued*.

*Premiums are based on your age at date of issue and will not increase due to your age or health status. Coverage will not be reduced during your level term period. The initial premium rates will not change for the first 10 years unless the insurance company exercises its right to change the premium rates for all insureds covered under the group policy with 60 days advance written notice. The level term rate period begins on the effective date assigned by ReliaStar Life Insurance Company.

The classes of rates are “Preferred” and “Tobacco.” Nontobacco users qualify for the higher “Preferred” rates. (Note: Tobacco users only qualify for “Tobacco” rates.) Upon approval of your application by the insurer, you will be notified of the rate classification for each approved person.

If applicable, an additional \$2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment method.

About This Plan Information

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. The complete terms and conditions of coverage are contained in Group Policy 67941-1, which is issued to the Illinois State Bar Association by ReliaStar Life Insurance Company. This is a paid endorsement. The ISBA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

Policy Form LP00GP

How to Apply

1. Complete, date and sign the Application included in the package. Be sure to indicate the coverage amount of your choice.
2. Do not send any money until ReliaStar Life Insurance Company has approved your Application and notifies you of the premium contribution due, based on the information you have provided.
3. Mail your completed Application to:
ISBA Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-8812

Administered by:



AMBA Administrators, Inc.
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?

1-800-503-9230

Association Member Benefits Advisors, LLC.
AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits &
Insurance Agency

Group Term Life Insurance Underwritten By: ReliaStar
Life Insurance Company
Minneapolis, MN

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