

FORMS PACKAGE FOR



Date Created:

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CORRESPONDENCE

Regular Mail

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SEARCH CRITERIA

Individual Life Insurance Application

General Account Products

New York

Agent's Checklist:

- Product, Product Type, Base Coverage, and Death Benefit questions have been completed.
- Supplemental Rider options have been selected. Refer to the product specs for specific information on rider availability.
- Required personal information for the Proposed Primary Insured has been completed.
- Required information for Primary and Contingent Beneficiaries has been completed.
- Questions regarding existing life insurance have been completed and detailed properly.
- Personal History Information have been completed and detailed thoroughly, where applicable.
- Medical Declarations have been completed for any proposed insured not completing a separate Part II Medical Examination.
- The "Signed At" and "Date" fields have been completed along with appropriate signatures under the Representations, Acknowledgement and Authorization section.
- The Agent's Report has been completed and submitted with the application.
- When applicable, the Electronic Funds Transfer form has been completed.
- An Authorization for Release of Health-Related Information has been submitted for each Proposed Insured/Proposed Other Insured with the application.
- Appendices A, C and D have been given to the Proposed Insured.
- A copy of this application has been provided to the Owner and/or Proposed Primary Insured.
- State required notices were provided at time of application. Refer to the Forms Wizard tool on the ING for Professionals website, via www.inglifeinsurance.com, for the forms required.

Reminders:

- Do not use pencil or correction fluid.
- Do not waive any of our requirements or any information that we request. You do not have the authority to make or modify contracts.
- Do not promise or imply that we will provide insurance.
- DO NOT ACCEPT MONEY OR ISSUE THE TEMPORARY INSURANCE RECEIPT if any representations in the Temporary Insurance Receipt (Appendix A) are answered **"Yes"** or **left blank**.
- Do not accept payment in the form of cash/currency or traveler's checks.
- Do not accept a check or money order made payable to you or with the payee left blank.
- Do not accept payment if the Proposed Insured has attained age 70.

THIS APPLICATION MAY NOT BE USED IF THE POLICY TO BE PURCHASED IS OR MAY BE USED FOR THE BENEFIT OF A THIRD PARTY (A "STRANGER") THAT LACKS AN INSURABLE INTEREST IN THE INSURED. A PERSON GENERALLY HAS AN INSURABLE INTEREST IN THE LIFE OF AN INSURED WHERE THE PERSON HAS A CONTINUED INTEREST IN THE SURVIVAL OF THE INSURED. THE COMPANY OPPOSES STRANGER-OWNED/STRANGER-ORIGINATED LIFE INSURANCE TRANSACTIONS ("STOLI") AND WILL SEEK TO TERMINATE ANY SUCH INSURANCE COVERAGE WHILE RETAINING PREMIUMS PAID, COSTS AND/OR DAMAGES. MATERIAL MISREPRESENTATION REGARDING THE FACTS PRESENTED TO THE COMPANY FOR UNDERWRITING THE APPLICATION OR ATTEMPTS TO DEFRAUD THE COMPANY MAY RESULT IN ADDITIONAL LEGAL ACTION. PLEASE SEE PAGE 1 AND SECTION R OF THE APPLICATION.

Mail or fax all completed materials to the ING Customer Service Center

Mail to: ING Customer Service Center, PO Box 5075, Minot, ND 58702-5075

Fax to: 866-816-9910; Attn: ING Customer Service Center

Get confirmation from your General Agent to send applications directly to us.

INDIVIDUAL LIFE INSURANCE APPLICATION (NY)

ReliaStar Life Insurance Company of New York, Woodbury, NY

A member of the ING family of companies ("the Company")

This application may not be used if the policy to be purchased is or may be used for the benefit of a third party (a "stranger") that lacks an insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. The Company opposes stranger-owned/stranger originated life insurance transactions ("STOLI") and will seek to terminate any such insurance coverage while retaining premiums paid, costs and/or damages. Material misrepresentation regarding the facts presented to the Company for underwriting the application or attempts to defraud the Company may result in additional legal action. Please see Section R of the application.

PART I - A. PRODUCT INFORMATION

1. Product Requested _____ 2. Product Type: General Account Variable Account

If applying for a variable life insurance policy, the proposed owner must receive a current prospectus and complete the Fund Allocation of Premium Payments form. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS AND THE CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNTS. AN ILLUSTRATION OF BENEFITS, INCLUDING DEATH BENEFITS, POLICY VALUES AND CASH VALUES, IS AVAILABLE UPON REQUEST.

3. Base Coverage: \$ _____ (Not including Term Riders - See Section B for Adjustable Term Insurance Rider.)

4. Death Benefit Option: (If no option is selected, option will default to A.)

- A or 1 - Level B or 2 - Increasing or Variable
 C or 3 - Face Amount + Premium D or 4 - Face Amount + Premium + Interest _____ %

5. Death Benefit Qualification Test: (If no option is selected, option will default to Guideline Premium Test.)

- Guideline Premium Test Cash Value Accumulation Test

6. Is the insurance employer-sponsored? Yes No

7. List all applications that are concurrently being submitted to ING for the Insured's family members and/or business partners.

Company Name _____ Amount \$ _____
Company Name _____ Amount \$ _____

If the policy will be owned by a "Funded ERISA Plan", complete question 8, specify the plan and trust type and provide the other information requested.

8. Is the insurance for a tax-qualified, pension, profit sharing or defined contribution ERISA plan, or a VEBA or welfare benefit arrangement? . Yes No

Plan Provider Name _____

- Tax-qualified plan (specify profit sharing, defined benefit, or defined contribution) _____
 Section 419/419A(f)(6) welfare benefit or VEBA plan Other (specify type and name of plan) _____

PART I - B. RIDER INFORMATION (Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)

Signed illustration is required for cash value products.

- Accidental Death Benefit Rider \$ _____
 Additional Insured Rider (Complete Part I - D.) \$ _____
 Adjustable Term Insurance Rider (Specify Target Death Benefit) _____ \$ _____
 Children's Insurance Rider (Complete Children's Insurance Rider Application.)
 Guaranteed Death Benefit Rider (An option below must be selected.)
 Lifetime 20-Year To age 65 or 20 years, if later
 Guaranteed Minimum Accumulation Benefit Rider
 Overloan Lapse Protection Rider
 Waiver of Cost of Insurance Rider
 Waiver of Monthly Deduction Rider
 Waiver of Premium (Term only)
 Waiver of Specified Premium Total Disability Rider (Specify monthly premium - illustration required) \$ _____
 Waiver of Surrender Charge Rider
 Other _____
 Other _____

PART I - C. PROPOSED PRIMARY INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____

2. Birth Date _____ SSN _____ Birth State/Country _____ Gender: M F

3. Residence Address (PO Boxes are not permitted.) _____
City _____ State _____ ZIP _____

4. Daytime Phone (_____) _____ Evening Phone (_____) _____

5. Best Time to Call _____ E-mail _____

6. Are you a U.S. Citizen? (If "No," complete the Foreign Travel and Residence Questionnaire.) Yes No

PART I - C. PROPOSED PRIMARY INSURED INFORMATION (Continued)

- 7. Occupation/Duties _____
- 8. Employer _____ Phone (_____) _____
- 9. Employer Address _____
- 10. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches) Yes No
If "Yes," indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____
- 11. Driver's License Number _____ 12. Driver's License State _____
(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
- 13. Name on Driver's License (if different than above) _____

PART I - D. PROPOSED OTHER INSURED INFORMATION

- 1. First Name _____ MI _____ Last Name _____
- 2. Birth Date _____ SSN _____ Birth State/Country _____ Gender: M F
- 3. Residence Address (PO Boxes are not permitted.) _____
City _____ State _____ ZIP _____
- 4. Daytime Phone (_____) _____ Evening Phone (_____) _____
- 5. Best Time to Call _____ E-mail _____
- 6. Are you a U.S. Citizen? (If "No," complete the Foreign Travel and Residence Questionnaire.) Yes No
- 7. Occupation/Duties _____
- 8. Employer _____ Phone (_____) _____
- 9. Employer Address _____
- 10. Do you currently use or have you ever used tobacco or nicotine products in any form? (e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches) Yes No
If "Yes," indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____
- 11. Driver's License Number _____ 12. Driver's License State _____
(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
- 13. Name on Driver's License (if different than above) _____

PART I - E. PROPOSED OWNER/TRUST/CORPORATION INFORMATION (If Proposed Owner is a Trust or Corporation, provide first and last pages of the Trust document, including signatures. The Trust must be established prior to the application date.)

- 1. Full Name of Owner/Trust/Corporation (30 character limit) _____
- 2. Owner Relationship to Proposed Primary Insured _____
- 3. Owner Birth Date _____ Owner Phone (_____) _____ Owner SSN/TIN _____
- 4. Owner Address (PO Boxes are not permitted.) _____
City _____ State _____ ZIP _____
- 5. Corporation Contact Name _____
- 6. Address of Trust/Corporation _____
- 7. Billing Address _____
- 8. Type of Government Issued ID (Driver's License/Passport) _____ Document Number _____
Issuing State or Country _____ Issuance Date _____ Expiration Date _____
- 9. Trust Contact Name _____ TIN _____ Trust Date _____
- 10. Purpose of the Trust _____ Type of Trust: Revocable Irrevocable
- 11. State of Incorporation _____ Trustee/Corporate Officer Name _____
- 12. Does the above trustee have sole authority to act on behalf of the Trust? Yes No
(If "No," list the names & addresses of all trustees on a separate page, and obtain signatures from all trustees on the application.)

PART I - F. BENEFICIARY INFORMATION

Unless otherwise stated, the beneficiary designation is revocable and beneficiaries of like class shall share rights of survivorship equally. If Trust or Corporation, provide name and date of trust agreement and state of incorporation. Percentages must total 100%, using whole percentages only. If additional space is needed, use Section Q.

1. Is the Beneficiary a Trust? Yes No

2. Trust Name _____ Trust Date _____ State of Incorporation _____

	Name (First, MI, Last)	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
Proposed Primary Insured			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
Proposed Other Insured			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
			<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

PART I - G. PERSONAL HISTORY (Questions 1-7 must be completed for all Proposed Insureds.)

- | | Proposed Insured | Proposed Other Insured |
|--|--|--|
| 1. Are you, or do you intend to become a member of the armed forces, including the Reserves?
(If "Yes," complete Military Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you intend to travel or reside outside the United States or Canada in the next two years? (If "Yes," complete the Foreign Travel and Residence Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you in the last five years made or do you anticipate in the next two years making flights in an aircraft OTHER than as a passenger on a scheduled airline? (If "Yes," complete the Aviation Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you participate in hang-gliding, soaring, sky-diving, ballooning, skin or scuba diving, mountain climbing, competitive skiing, or rodeos? (If "Yes," complete the appropriate Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you race, test or stunt drive automobiles, motorcycles, motor boats, or jet powered vehicles, or do you use or race snowmobiles, dirt bikes, or dune buggies? (If "Yes," complete Avocations and Professional Sports Questionnaire.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Except for traffic violations, have you been convicted in a criminal proceeding or are you the subject of a pending criminal proceeding? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you in the last five years had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For any "Yes" answer to questions 6-7, please record information in the chart below.

Question	Proposed Insured/Proposed Other Insured	Explanation

PART I - H. PAYMENT INFORMATION

- 1. Initial Payment: Check Cash on Delivery 1035 Exchange ING Internal or Affiliated Exchange/Surrender
2. Initial Payment Amount \$ _____ Planned/Scheduled/Modal Payment \$ _____
3. Frequency of Subsequent Payments: Annually Semi-Annually Quarterly Monthly1
 Military Allotment2 (Active or retired military members must complete the Military Allotment form and return it to the military finance department.)
 Civil Service Allotment (The Federal Civil Service Application Checklist, Bank Allotment Authority, and Employer 1199 for Direct Deposit forms must be completed.)

1 Available with electronic funds transfer.
2 Two monthly premium payments are required before the policy becomes active.

PART I - I. LIST BILL INFORMATION - EMPLOYER-SPONSORED PLANS ONLY (For a new List Bill plan, please contact the List Bill Department at 877-886-5050.)

- 1. Is the insurance employer-sponsored? Yes No List Bill/File Code Number (if plan already exists) _____
2. Employer Plan Name (if plan already exists) _____ 3. Phone (_____) _____
4. Address _____

PART I - J. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? Yes (If "Yes," review the policy backdating notice below.)

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

I understand, on backdated policies, that the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

PART I - K. FINANCIAL DETAILS

- 1. Will the applicant accept this policy if it is a "Modified Endowment Contract" at issue? Yes No
2. Is the policy in accordance with your insurance objectives and your anticipated financial needs? Yes No
3. Do you believe you have the financial ability to continue making premium payments on this policy? Yes No
4. Have you or your company ever declared bankruptcy? (If "Yes," provide details including date discharged.) Yes No

Personal Insurance (For Personal Insurance complete questions 5-7; for Business Insurance complete questions 8-11.)

- 5. Purpose of Insurance: Estate Liquidity Family Protection Tax Planning Retirement Planning Cash Accumulation
 Other _____

Table with 3 columns: 6., Annual Earned Income, Annual Interest and Other Income. Rows: Proposed Primary Insured, Proposed Other Insured.

7. Total Assets \$ _____ Total Liabilities \$ _____ Total Net Worth \$ _____

PART I - K. FINANCIAL DETAILS (Continued)

Business Insurance (For Business Insurance complete questions 8-11.)

8. Purpose of Insurance: Buy/Sell Key Person Other _____

9. Total Business Assets \$ _____ Total Business Liabilities \$ _____ Total Business Net Worth \$ _____

10. Business Net Profit After Taxes for Past Two Years: Last Year \$ _____ Previous Year \$ _____

11. Owner Name	Title	Amount of Business Coverage in force	Percentage of Ownership	Active in Business?
		\$	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	%	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART I - L. EXISTING INSURANCE AND REPLACEMENT INFORMATION (Applies to the proposed primary insured, any proposed other insured, and the proposed owner.)

New York state law requires the agent to provide the form Insurance Department of the State of New York Appendix 11 - Definition of Replacement for your review and signature. If you answered "Yes" to any of the questions on the Appendix 11 - Definition of Replacement form, the agent must provide you with form Appendix 10A - Insurance Department of the State of New York Disclosure Statement, as well as other information that will help you compare the policy you are applying for with the policy you intend to replace. If you are undecided about keeping your existing coverage, indicating on both the Definition of Replacement form and the application an intention to replace or change existing coverage may help you obtain the information you need to make a final decision. If you do replace or change existing coverage, the new policy may contain, among other things, new suicide exclusion and contestability periods and/or withdrawal or surrender charges.

		Proposed Insured		Proposed Other Insured		Proposed Owner	
		Yes	No	Yes	No	Yes	No
1. Do you have an existing or pending life insurance policy or annuity contract? (If "Yes," provide details in the table below.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. All Life Insurance Coverage in Force (including all policies sold or used as life settlements):

Insured Name	Insurance Company (Do include group policies.)	Contract / Policy Number	Account Value / Amount of Coverage	Year Issued

PART I - M. MEDICAL TRANSFER STATEMENT (Complete when submitting medical examinations of another insurance company.)

1. Insurance Company Name _____ 2. Examination Date _____

		Proposed Insured		Proposed Other Insured	
		Yes	No	Yes	No
3. To the best of your knowledge and belief, are the statements in the examination true and complete today?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you consulted a medical doctor or other practitioner since the examination indicated in question 1 above? (If "Yes," complete Part II - Medical Declarations.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART I - N. SUITABILITY/NEEDS ANALYSIS - VARIABLE PRODUCTS ONLY (Completed by the Proposed Owner. Failing to provide this information will result in a delay in the issuing of new business.)

1. Have you received a current prospectus including supplements for the variable life insurance policy? Yes No
Provide date of policy prospectus/supplement _____

2. Do you understand that:
- a. The amount or duration of the policy death benefit may vary under specified conditions; **Policy values may increase or decrease with the investment experience of the variable investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division and/or the Indexed Credit Strategy, if applicable; The amount payable is not guaranteed, but is dependent on the account value and amounts owed under the policy?** Yes No
 - b. The fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? Yes No
 - c. Personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience of the variable investment options or of actual interest credited in the general account option(s)? Yes No

PART I - O. TELEPHONE PRIVILEGES - INDEXED AND VARIABLE PRODUCTS ONLY

I understand that I may indicate below whether to allow telephone privileges to be provided to me and/or my agent/registered representative and his/her assistant. Telephone privileges allow an authorized person to call the Company to make certain elections and request certain transactions. The Company may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. By accepting telephone privileges, I authorize the Company to record my telephone calls to the Company. The Company and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be genuine.

- I understand that if I do not want to authorize telephone privileges, I should not check either of the two boxes below. I also understand that once granted, such privileges will be revoked by upon receipt by the Company of signed, written instructions to terminate telephone privileges.
- I want telephone privileges.
 - I want telephone privileges granted to my agent/registered representative and his/her assistant.

PART I - P. REPLACEMENT VERIFICATION (For Agent use ONLY)

1. To the best of your knowledge and belief, will any existing life or annuity coverage be replaced, lapsed, surrendered, or borrowed against? (If "Yes," submit New York required replacement forms.) Yes No
- a. Is the applicant considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating their existing policy or contract? (If "Yes," complete New York required replacement form and provide details below.) Yes No
 - b. Is the applicant considering using funds from their existing policies or contracts to pay premiums due on the new policy or contract? (If "Yes," complete New York required replacement form.) Yes No
- Company _____ Policy Number _____ Amount \$ _____

PART I - Q. NOTES

Use this space to provide any additional details to questions answered throughout the application. Please understand that if you provide the Company with information on this page it will be considered part of your Individual Life Insurance Application.

Section	Question	Details

PART I - R. ING'S POLICY ON STRANGER-OWNED OR STRANGER-ORIGINATED LIFE INSURANCE (STOLI)

The Company, along with other ING Life Companies strongly opposes arrangements designed to obtain life insurance for the benefit of a third party (a "stranger") that has no insurable interest in the insured. A person generally has an insurable interest in the life of an insured where the person has a continued interest in the survival of the insured. We believe this position supports the best interests of our policy owners, as stranger-owned or stranger-originated life insurance transactions ("STOLI") will lead to higher costs for consumers and undermine the concept of insurable interest, a core element of the life insurance business. The Company will seek to terminate the insurance coverage under any contract determined to be STOLI or where material misrepresentation has occurred regarding the facts presented to the Company for underwriting the application. Attempts to defraud the Company may result in additional legal action.

The Company does not sell life insurance in the following circumstance:

- If, at the time of sale or conversion, the applicant/owner has an intent, plan, arrangement or understanding with a third party that will result directly or indirectly in the sale, assignment, settlement or other transfer to an investor, such as a life settlement company, or any other party with no insurable interest in the life of the insured who purchases the policy for investment purposes;
- If, at the time of sale or conversion, the applicant/owner has an intent, plan or arrangement to transfer an ownership interest or beneficial interest in an entity that will own the policy to a life settlement company or any other party with no insurable interest in the life of the insured;
- If, in connection with the sale, the applicant/owner and/or the insured is offered any compensation, reward or benefit, or other inducement to purchase or assist in the purchase the policy, including, but not limited to, cash payments, property such as a life insurance death benefit for "free" or at "no cost" or any other benefit of any kind;
- Where a sales concept, design, marketing plan, marketing material or other program that has not been disclosed to the Company is used in connection with the sale (including, but not limited to, any nontraditional premium finance program, such as "non-recourse" lending arrangement where the lender's sole collateral for the premium loan is limited to the values of the policy itself);
- Where the producer and/or applicant knows, or has reason to know, that the source of funds for premium payments under a policy has not been disclosed to the Company (including, but not limited to, any arrangement to pay for premiums under the policy through a loan through a premium financing arrangement or other third party funding) ; or
- In any other circumstance determined by the Company, in its sole discretion, to be inconsistent with our policies on STOLI, insurable interest or misrepresentation.

The activities described above are considered "prohibited conduct".

PART I - S. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION

Representations and acknowledgements: By signing this form, I acknowledge that I have read this application and I agree with the statements in this application and represent that all questions have been truthfully answered to the best of my knowledge and belief. The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully. This application consists of all pages of the application, appendices, and supplemental questionnaires. It will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein. Unless otherwise stated in a Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, and the first premium is received by the Company while the Proposed Insured is alive. If I have paid premium with this application, I have completed the Temporary Insurance Receipt, which is Appendix A of this application. The producer does not have the authority—unless permitted by law—to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements. No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing. If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force. I understand that by signing this application, I am applying for life insurance coverage issued by the Company.

By my signature on the next page, I affirmatively warrant and represent that I have not engaged in any prohibited conduct described in Section R above in connection with this application for insurance.

Authorization and Statements of Understanding: I authorize the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this application. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me and any minor children who are to be insured. I give my permission to the Company to send any information obtained to MIB, Inc., reinsurers, the producer who solicited my application and his or her principals, employees or contractors who process transactions regarding insurance coverage for which I have applied. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original.

PART I - S. REPRESENTATIONS, ACKNOWLEDGEMENT AND AUTHORIZATION (Continued)

I acknowledge receipt of the following disclosures and notices: Accelerated Benefit Rider Disclosure, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices. **I acknowledge that receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable and that the Accelerated Benefit is subject to a lien which includes an administrative charge not to exceed \$300 payable when the benefit is elected.** I certify, under penalty of perjury, that my Social Security Number/tax identification number is shown and is correct and that I am not subject to back-up withholding.

If an investigative consumer report is prepared, I request to be interviewed. Yes (If "No" leave the checkbox blank.)

Interview Information: Daytime phone number: (_____) _____

Contact me between the hours of _____ a.m./p.m. and _____ a.m./p.m.

By my signature below I acknowledge and agree that any policy issued in relation to this application (the "Policy") shall be subject to the following Governing Law and Jurisdiction provisions:

Governing Law. The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.

Jurisdiction. Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

All completed materials must be sent to the ING Customer Service Center at: 2000 21st Ave. NW, Minot, ND 58703

This application will be attached to and become part of the policy.


Proposed Owner Signed at (city/state) _____ Date _____

 Proposed Owner Signature (if other than the Insured) _____ Date _____

 Proposed Insured Signature _____ Date _____
(if age 15 or older)

 Proposed Other Insured Signature _____ Date _____

Proposed Owner/Trustee Name (please print) _____

 Parent or Guardian Signature _____
(if the Proposed Owner or the Proposed Primary Insured is a minor)

By signing below I acknowledge that I have not engaged in prohibited conduct as described in Section R, "ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI)," nor am I aware of such conduct by the applicant

 Writing Agent Signature _____ Date _____

Writing Agent Name (please print) _____

Writing Agent State Lic. Number _____ Writing Agent Number _____

**INDIVIDUAL LIFE INSURANCE APPLICATION PART II -
MEDICAL DECLARATIONS (NY)**

ReliaStar Life Insurance Company of New York, Woodbury, NY
A member of the ING family of companies



For any proposed insured not completing a separate Part II Medical Examination, questions 1-16 below must be completed. Provide names and other data of Proposed Insured and all Proposed Other Insureds.

Proposed Primary Insured

- 1. Height _____ Weight _____ Loss or gain in pounds during the last year _____
- 2. Personal Physician Name _____ Physician Phone (_____) _____
- 3. Physician Address _____ City _____ State _____ ZIP _____
- 4. Date last seen by Physician _____ 5. Reason for Consultation _____
- 6. Results of Consultation _____

Proposed Other Insured

- 7. Height _____ Weight _____ Loss or gain in pounds during the last year _____
- 8. Personal Physician Name _____ Physician Phone (_____) _____
- 9. Physician Address _____ City _____ State _____ ZIP _____
- 10. Date last seen by physician _____ 11. Reason for Consultation _____
- 12. Results of Consultation _____

	Proposed Insured	Proposed Other Insured
13. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:		
a. Dizziness, seizures, convulsions, headaches, paralysis, stroke, TIA, or a mental or nervous disorder, including anxiety or depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or any other disorder of the stomach, intestine, liver, pancreas, or gall bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or any other disorder of the kidneys, bladder, breasts, prostate, or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes, thyroid, or any other endocrine disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Disorder of the skin or lymph glands, arthritis, or any disorder of the muscles, joints, nerves or bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Anemia or any other disorder of the blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you:		
a. Had any operation(s) in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. In the past 5 years been advised to have operation(s), treatments, or diagnostic tests that have not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years (excluding HIV testing)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? (If "Yes," complete Alcohol Usage or Drug Use Questionnaire.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. In the past 5 years been confined for observation, care, or treatment in a hospital or other health care facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. In the past 5 years, consulted any health care provider(s) not already identified, for any reason including routine physical examination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are you:		
a. Presently taking any medication(s), including non-prescription/over the counter medication or supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? (If "Yes," complete Drug Use Questionnaire.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

For any "Yes" answer to questions 13-15 please record information in chart below. If you need additional space, please attach a separate piece of paper to the application.

Question	Person	Condition/Diagnosis	Dates/Duration of Condition/Treatment	Physician Name	Physician Address

16. Family History							
Proposed Insured				Proposed Other Insured			
	Age if Living	Age at Death	Cause of Death		Age if Living	Age at Death	Cause of Death
Father				Father			
Mother				Mother			
Brother(s)				Brother(s)			
Sister(s)				Sister(s)			

I have read the declarations above and affirm that they are complete and true to the best of my knowledge and belief.

Signed at (city, state) _____ Date _____

 Proposed Insured Signature (if age 15 or older) _____ Date _____

 Proposed Other Insured Signature _____ Date _____

 Parent or Guardian Signature (if the Proposed Primary Insured is a minor) _____ Date _____

TEMPORARY INSURANCE RECEIPT

ReliaStar Life Insurance Company of New York, Woodbury, NY

A member of the ING family of companies ("the Company")



I. PREMIUM RECEIPT (On the lives of the Proposed Primary Insured and Proposed Other Insured named below)

Amount Received \$ _____ Date _____ Policy Application Date _____

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS (For each Proposed Insured named below)

- 1. Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
a. any type of heart disease, stroke or other vascular disease?
b. any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system?
2. In the past five years has any Proposed Insured experienced unintentional weight loss?
3. Has any Proposed Insured attained age 70?

III. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders covering the life or lives of the Proposed Insured(s) if issued as applied for under the Application; or (b) \$1,000,000.

If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the issue date, premiums are due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
• Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
• Coverage starts under any policy resulting from the Application; or
• A policy resulting from the Application is refused; or
• 90 days after the date this form is signed.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.

There is no temporary insurance receipt coverage if:

- Any of the above representations is answered YES or LEFT BLANK.
• If Section 1035 exchange paperwork is received without premium payment.
• There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
• A Proposed Insured dies by suicide or intentional self-inflicted injury.
• No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name (please print) _____ Signed at (city/state) _____

Proposed Owner Signature _____ Date _____

Proposed Insured Name (please print) _____ Signed at (city/state) _____

Proposed Insured Signature (if other than the Proposed Owner) _____ Date _____

Proposed Other Insured Name (please print) _____ Signed at (city/state) _____

Proposed Other Insured Signature _____ Date _____

Writing Agent Name (please print) _____ Agent Phone (_____) _____

Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE CENTER 2ND COPY TO PROPOSED INSURED

TEMPORARY INSURANCE RECEIPT

ReliaStar Life Insurance Company of New York, Woodbury, NY

A member of the ING family of companies
("the Company")



I. PREMIUM RECEIPT *(On the lives of the Proposed Primary Insured and Proposed Other Insured named below)*

Amount Received \$ _____ Date _____ Policy Application Date _____

Premium for this receipt must be at least the first modal premium for the insurance policy. Premium may be paid by check or authorized withdrawal. Make all checks payable to the Company, not the agent.

II. REPRESENTATIONS *(For each Proposed Insured named below)*

- Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("Health Care Provider") as having:
 - any type of heart disease, stroke or other vascular disease? Yes No
 - any type of cancer, leukemia, malignant tumor or disorder of the brain or immune system? Yes No
- In the past five years has any Proposed Insured experienced unintentional weight loss? Yes No
- Has any Proposed Insured attained age 70? Yes No

III. TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders covering the life or lives of the Proposed Insured(s) if issued as applied for under the Application; or (b) \$1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Company is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Company's total liability shall not exceed \$1,000,000; and the \$1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s). No death benefit is payable for a second to die or last survivorship policy unless both Proposed Insureds die while this coverage is in effect.

General: All the above representations are true and complete to the best knowledge and belief of the Proposed Owner and the Proposed Insured(s). The Proposed Owner agrees that they are to be relied on for this coverage. No agent can waive or modify this coverage in any way. Premium(s) will be returned if a policy is not delivered and no benefit is paid under this coverage.

If a policy is delivered, premium(s) will be applied to the first policy premium. Premiums are billed from the policy date. If the policy date is prior to the issue date, premiums are due based on the policy date.

Coverage begins when Part I of the Application is completed, a premium has been accepted, and this form has been completed and signed.

Coverage ends automatically on the earliest of the following dates:

- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
- Coverage starts under any policy resulting from the Application; or
- A policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this coverage any time before delivery of the policy.

This Temporary Insurance Receipt does not provide any coverage except as provided herein.

There is no temporary insurance receipt coverage if:

- Any of the above representations is answered YES or LEFT BLANK.
- If Section 1035 exchange paperwork is received without premium payment.
- There is material misrepresentation in the answers to the representations above or to any question or statement in the Application.
- A Proposed Insured dies by suicide or intentional self-inflicted injury.
- No premium is paid with this receipt, or if the premium check or authorized withdrawal is not honored.

Proposed Owner Name *(please print)* _____ Signed at *(city/state)* _____

➡ Proposed Owner Signature _____ Date _____

Proposed Insured Name *(please print)* _____ Signed at *(city/state)* _____

➡ Proposed Insured Signature
(if other than the Proposed Owner) _____ Date _____

Proposed Other Insured Name *(please print)* _____ Signed at *(city/state)* _____

➡ Proposed Other Insured Signature _____ Date _____

Writing Agent Name *(please print)* _____ Agent Phone (_____) _____

➡ Writing Agent Signature _____ Date _____

1ST COPY TO CUSTOMER SERVICE CENTER 2ND COPY TO PROPOSED INSURED

AGENT'S REPORT

To be completed by the Agent. For questions about this application or requirements, contact the underwriting department.

Agent Name/Broker-Dealer (please print)	Agent ID Number	% Split	General Agent Number	General Agent Name

A. COMPLIANCE INFORMATION

- Did you meet personally with the Proposed Owner and review their government issued ID? (If "No", explain in Section D.) Yes No
- Did you obtain the Proposed Insured's Medical Declarations in person and record them in the presence of the Proposed Insured? (If "No", explain in Section D and arrange for an exam.) Yes No
- Was an initial premium payment accepted? Yes No
If "Yes", was the Temporary Insurance Receipt completed and delivered to the Proposed Insured or Proposed Owner? Yes No
- Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? Yes No
- Has the Proposed Owner or Proposed Insured previously sold or assigned a policy to a life settlement or viatical company? Yes No
If "Yes", provide details. _____
- Will financing (using any source other than the client's assets) of premium payments be used now or is it contemplated within the next two years? . Yes No
a. If "Yes", complete the Financing Disclosure & Acknowledgment.
b. If "No", what is the source of funds used to pay premiums on this policy? (Check all that apply below.)

	Initial	Future
Current income	<input type="checkbox"/>	<input type="checkbox"/>
CDs or savings	<input type="checkbox"/>	<input type="checkbox"/>
Mutual funds or brokerage account	<input type="checkbox"/>	<input type="checkbox"/>
Existing life insurance policy(ies) or annuity contract(s)	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

B. PROPOSED INSURED/OWNER INFORMATION

- How long have you known the Proposed Insured? _____ 2. Are you related? Yes No How? _____
- How much life insurance is in force on the Proposed Insured's spouse/domestic partner, payable to the Proposed Insured or other dependents? \$ _____
- What is the annual income of the Proposed Insured's spouse or domestic partner? \$ _____
- If this application is for a juvenile, indicate the amount of life insurance in force on each parent or sibling.
Father \$ _____ Mother \$ _____ Sibling \$ _____
- If underwriting requirements were ordered, which paramedical vendor was used? _____

C. RELATED APPLICATIONS (List all applications that are concurrently being submitted to ING for the Insured's family members and/or business partners.)

Proposed Insured Names and Amounts applied for _____

D. REMARKS (Use this area to request alternates/optionals, including the selection of alternative commission structures, where available.)

E. ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I acknowledge my receipt and acceptance of the terms of the current ING Life Companies General Agent Producer or other agent agreement ("Agreement"), including but not limited to any compensation schedules. I agree to be bound by the terms and conditions of that Agreement, unless I am an employee/registered representative of a Broker/Dealer and do not hold an Agreement such that this language is inapplicable. I understand that I may receive an additional copy of my Agreement and/or current compensation schedule, from the Company, by contacting Distributor Services at 877-882-5050.

I certify that all sales materials used during this sale were approved by the Company. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Company's corporate policy. I acknowledge that I have delivered the Important Notices (Consumer Privacy Notice & MIB) to the Proposed Insured(s) or Proposed Owner. I affirm that the answers above are complete and true to the best of my knowledge and belief.

 Agent Signature(s) _____ Date _____
 Contact for Requirements _____ Agent SSN (Optional - Last 4 digits only) _____
 Agent Phone _____ Fax _____ E-mail _____

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization is HIPAA compliant.

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name *(please print)* _____

Birth Date _____ SSN/TIN _____

Proposed Insured/Patient Address _____

City _____ State _____ ZIP _____

AUTHORIZATION INFORMATION

This will authorize: _____ *(Physician, Clinic or Hospital Name)*

to release medical information to _____ *(the Life Insurance Agent/Agency).*

Authorized Life Insurance Carrier(s) _____

The information to be released or disclosed for the purpose of a life insurance application includes any and all health-related information and medical records, including chemical dependency/drug or alcohol abuse treatment records, pathology reports, radiology reports and films, and lab reports, within the past 10 years (unless otherwise provided by state law).

The purpose of this authorization is to assist in the evaluation and placement of my application for life insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, according to the terms of this authorization. This includes any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition. Some examples of the type of information to be released include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions; (4) HIV testing and treatment (except where prohibited by law); (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or health care provider that has provided payment, treatment or services to me or on my behalf ("my providers") within the past 10 years (unless otherwise provided by state law) to disclose my entire medical record and any other protected health information concerning me to the Life Agent/Agency named above and its agents, employees, representatives and the insurance carrier(s) listed on this authorization. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

Protected health information is to be disclosed under this authorization so that the Life Agent/Agency may provide the information to the listed carrier(s) so that they may: 1) underwrite my application for coverage and make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Life Agent/Agency.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Life Agent/Agency named above at the following address.

Attention: Privacy Official

Agency Address _____

City _____ State _____ ZIP _____

I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the insurance carrier(s) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by state insurance privacy rules and by the security standards of the listed carrier(s).

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the insurance carrier(s) may not be able to process my Application or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

 Proposed Insured/Patient or
Personal Representative Signature _____ Date _____

Description of Personal Representative's
Authority or Relationship to Patient *(please print)* _____

A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PROPOSED INSURED/PROPOSED OTHER INSURED.

IMPORTANT NOTICES

ReliaStar Life Insurance Company of New York, Woodbury, NY

A member of the ING family of companies
("the Company")



CONSUMER PRIVACY NOTICE

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, the Company ("we") will send you the name, address, and phone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. 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, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records or by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. 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 the Company unless you request otherwise.

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; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We will treat the information regarding your insurability as confidential. We and our reinsurers may, however, make a brief report to the Medical Information Bureau (MIB), Inc. MIB is a nonprofit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another MIB member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The mailing address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. The phone number is 866-692-6901 and the fax number is 866-346-3642. The MIB website address is www.mib.com.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Federal Regulations - 42CFR Part 2

Your medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. If information is protected by federal or state law, you may revoke this authorization at any time by mailing a written request to the Company. A written request, however, will not apply to any information collected before the date that we receive your request.

IMPORTANT INFORMATION

To help the government fight the funding for terrorism and money-laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you apply for life insurance, we will ask for your name, address, birth date, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

If you wish to have a more detailed explanation of our information practices, please write to:

ING Customer Service Center
Life New Business
PO Box 5053
Minot, ND, 58702-5053

This page must be given to the Proposed Insured.

ACKNOWLEDGEMENTS

Notice Regarding Collection of Information and Information Practices

In order to evaluate your application for life insurance, we must collect information about you and any minor children who are to be insured. The type of information that we may collect includes, but is not limited to, the following: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information about you or your minor children who are to be insured. Some of that information will come from you. Some will come from other sources.

The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically related facilities, insurance or reinsuring companies, Medical Information Bureau ("MIB"), Inc., any consumer reporting agencies, and any other organizations.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

Proposed Insured/Owner: By signing Section S on the Individual Life Insurance Application, the Proposed Insured acknowledges receipt of these notices.

Producer: By signing Section S on the Individual Life Insurance Application, the producers acknowledge that a copy of these notices have been provided.

This page must be given to the Proposed Insured.

ELECTRONIC FUNDS TRANSFER (EFT)

ReliaStar Life Insurance Company of New York, Woodbury, NY

("the Company")

A member of the ING family of companies

ING Customer Service Center, 2000 21st Ave. NW, Minot, ND 58703



Your future. Made easier.®

ELECTRONIC FUNDS TRANSFER

What is the EFT plan?

The EFT plan allows us to pay your policy premiums by automatically withdrawing funds from your financial institution's account.

What happens if my financial institution does not honor a withdrawal?

If your financial institution does not honor a withdrawal, your premium due will be considered unpaid. Premium payments are necessary to fund your policy; therefore, you will be required to send us a replacement payment. If we do not receive a replacement payment within the time required by your policy, your policy will enter its grace period and then lapse. Once a policy lapses, it no longer offers life insurance coverage. To help prevent this, we encourage you to obtain overdraft protection from your bank.

How much will be deducted from my account?

We will only deduct premium payments according to the payment schedule outlined in your policy.

How can I cancel the EFT plan?

You have two options. You can write to us as the address above. Once we receive your request, we will cancel the plan within 7 – 10 business days. You may also call us at 877-886-5050 to cancel the plan.

We may cancel the plan without notice if a withdrawal is not honored or 30 days after we provide written notice to you.

If the plan is cancelled, you must pay any unpaid and future premiums directly to us on the premium due date. Termination of the plan does not change the premium due dates.

I'd like to enroll. Where do I sign?

Please read the following agreement and sign and date this form.

Authorization Agreement for Prearranged Payments

I authorize the Company to withdraw funds from my checking or savings account, identified on the next page, to pay premiums on my life insurance policy. This authorization will remain in effect until the Company has received a written request or phone call from me to terminate this agreement.

Please Note: Premiums paid more frequently than annually may result in higher total premiums for the same coverage, depending on the product specifications.

This agreement authorizes: A new transfer A change in existing transfer amount A change in financial institution

Payment Frequency: Monthly Quarterly Semi-Annually Annually (Frequency other than monthly depends on the policy type.)

Insured Name (please print)	Policy Number	Deduction
		\$
		\$
		\$
		\$

Request Specific Draft Date for Recurring Payments¹ (Between the 1st and the 28th) _____

Bank Name _____ Account Type: Checking Savings

Bank Address _____

City _____ State _____ ZIP _____

Name(s) on Account _____

¹ Depending on the type of policy you own, the draft date options may vary. Please call us at 877-882-5050 option 1, option 1 for more information.

ELECTRONIC FUNDS TRANSFER *(Continued)*

For checking accounts, please tape a voided check in the space below. If you cannot provide this, you may write the bank routing number and account number in the appropriate fields.

Tape voided check here.

Routing Number (9 digits) _____ Account Number _____

 Account Owner Signature _____ Date _____

SSN/TIN _____ Phone (_____) _____

Sample Check

Routing # (9 digits)

 **Financial Institution**
MEMO _____ Not Negotiable
⑆ 987654321 ⑆ 1234567890123 ⑆ 5678

Account #

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
APPENDIX 11 - DEFINITION OF REPLACEMENT

ReliaStar Life Insurance Company of New York, Woodbury, NY
ING Customer Service Center, PO Box 5075, Minot, ND 58702-5075



IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

- 1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?
2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?
3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE POLICY OR ANNUITY BENEFITS WILL CONTINUE IN FORCE?
4. REISSUED WITH A REDUCTION IN THE AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?
5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?
6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN AMOUNT OF PREMIUM PAID?

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

APPLICANT SIGNATURE _____ DATE _____

APPLICANT SIGNATURE _____ DATE _____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION . . . YES NO

AGENT OR BROKER NAME _____ AGENT # _____

AGENT OR BROKER SIGNATURE _____ DATE _____

NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

ReliaStar Life Insurance Company of New York, Woodbury, NY

A member of the ING family of companies

ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



THE HIV ANTIBODY TEST

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done. A procedure will be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include but are not limited to determination of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, or the presence of medications, drugs, nicotine or their metabolites.

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when the infection occurred within the previous 3-6 months.

Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS or AIDS-related conditions. You may wish to consider further independent testing. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

AIDS INFORMATION

WHAT IS AIDS?

- AIDS stands for Acquired Immune Deficiency Syndrome, a disorder for which there is presently no cure.
- It is caused by a virus that many scientists call HIV (Human Immunodeficiency Virus). The virus can destroy the body's immune system, making it unable to fight off even small infections. The virus can also attack the nervous system, causing seizures, memory loss and mental disorders.
- The AIDS virus is carried in blood, semen, vaginal fluid and other body secretions of an infected person. The virus must get into your bloodstream to cause AIDS.
- As many as 300,000 to 500,000 New Yorkers may already be infected with the AIDS virus. Most of these people don't know they're infected, because they have no symptoms.

HOW DO YOU GET AIDS?

- By having sex with someone who has the AIDS virus. During sex with an infected person, the virus contained in blood, semen or other fluids can enter your body. It doesn't matter if you have sex with an infected person only once—you can still get AIDS!
- By shooting drugs with a needle or syringe that has been used by someone who has the AIDS virus. Invisible traces of infected blood from the last person who used the equipment could enter your body.
- A woman with the AIDS virus can give it to her unborn baby if she becomes pregnant. She is also more likely to develop AIDS if she becomes pregnant.

HOW DO YOU KNOW IF SOMEONE IS INFECTED?

- You can't tell if someone is infected with the AIDS virus just by looking at him or her.
- Most men and women infected with the virus don't know that they are infected, because they have no signs or symptoms of illness. It can take several years before symptoms develop.
- Anyone who has ever shared a needle to shoot drugs could be infected. Researchers think that half of IV drug abusers are already infected!
- Anyone who ever had sex with a man or woman who shoots drugs could be infected.
- Anyone who has had many sexual partners could be infected—the more sexual partners, the greater the chances.
- Anyone who has had anal sex has an increased risk of being infected.
- Anyone who has a medical condition which required blood transfusions could be infected.

HOW CAN YOU STAY SAFE FROM AIDS?

- Don't have sex with anyone if you don't know his or her drug use and sexual history.
- Don't have sex with a large number of partners; this increases your risk of AIDS and other sexually transmittable diseases.
- Don't have anal sex. It can tear delicate tissues, letting infected semen or blood enter your bloodstream.
- Use a condom during sex to help keep the virus from getting into your body—unless you're absolutely sure your partner is not infected.
- Using a spermicide containing nonoxynol-9 along with condoms may provide further protection.
- NEVER shoot drugs.
- NEVER share a needle or other equipment to shoot drugs.

COUNSELING

Many public health organizations have recommended that before taking an AIDS-related blood test a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your own physician or health care provider.

We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross for further information about counseling services in your area. In addition, the state of New York provides the following services to assist you with obtaining additional information about AIDS or AIDS-related conditions.

You may write to: The AIDS Institute
New York State Health Department
90 Church Street
13th Floor
New York, New York 10007-2919

For referral or assistance, you may also call:
The New York State AIDS Hotline toll-free number
1-800-541-AIDS

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician so that the Insurer can have him or her tell you the test results and explain the meaning. If you prefer, the results can be sent to you or another person.

In the event of a test result other than negative, I authorize disclosure to the following physician or other person or entity:

Name _____

Address _____

City _____ State _____ ZIP _____

If you prefer the results sent directly to you, initial here: _____

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to ensure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date shown below.

CONSENT

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of blood from me, the testing of my blood for HIV antibodies, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured Name (*Please print*) _____ Date _____

Address _____

City _____ State _____ ZIP _____

Proposed Insured Signature _____

ACCELERATED BENEFIT RIDER DISCLOSURE

ReliaStar Life Insurance Company of New York, Woodbury, NY
 A member of the ING family of companies
 ING Customer Service Center: PO Box 5075, Minot, ND 58702-5075



READ YOUR RIDER CAREFULLY

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policy owners should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policy owners should seek assistance from a qualified tax advisor.

There is no additional premium required for the Accelerated Benefit Rider; instead, a lien is associated with the acceleration and an administrative charge is required upon the exercise of the benefit.

- We will pay an Accelerated Benefit, at the Policy Owner's request, if the Insured has a Qualifying Condition. The Qualifying Condition for Payment of an Accelerated Benefit under this Rider is a medical or physical condition that results in a diagnosis that the Insured's life expectancy be 12 months or less from the date of receipt of a Physician Statement. Refer to the rider for more details.
- Other means may be available to the Policy Owner to achieve the intended goal, including a Policy Loan.
- The Policy Owner may request an acceleration of a portion of the Eligible Death Benefit, subject to a minimum Accelerated Benefit of the lesser of 25% of the Eligible Death Benefit or \$50,000, and a maximum Accelerated Benefit of the lesser of 50% of the Eligible Death Benefit or \$1,000,000. We will pay the amount requested reduced by an amount equal to any outstanding Policy Loan and accrued interest, and an administrative charge of \$300. The remainder will be paid to the Policy Owner. Other conditions and limitations, as described in the Rider, may apply.
- The Accelerated Benefit will be paid in a lump sum, unless the Policy Owner requests and we agree to payment in some other manner.
- Within five (5) days of receipt of the completed claim form, we will provide the Policy Owner with information showing how an Accelerated Benefit payment will affect the Policy (see below). Fourteen (14) days after we provide such information, payment of the Accelerated Benefit can be made.
- The requested Accelerated Benefit amount plus any premiums due on the date of the Accelerated Benefit payment will create a lien against the Policy. Interest on the amount of the Policy lien accrues daily and is added to the amount of the Policy lien. When there is a Policy lien, the amount payable at death is reduced by the amount of the Policy lien. Access to the Policy's Surrender Value will be limited to the excess of the Surrender Value over the amount of the Policy lien.
- Continued premium payment is required to keep the Policy in force. Unpaid premiums will be added to the Policy lien.
- No health care facility as defined in Section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

This summary provides a brief description of the important features of the Accelerated Benefit Rider. An example of the effect of an Accelerated Benefit request of \$125,000 is shown below.¹

Before Acceleration		Requested Acceleration = \$125,000		After Acceleration	
Death Benefit (Gross)	\$500,000	Death Benefit (Gross)		Death Benefit (Gross)	\$500,000
Premium	\$5,000	Premium		Premium	\$5,000
Account Value	\$21,000	Account Value		Account Value	\$21,000
Surrender Value	\$18,000	Surrender Value		Surrender Value	\$18,000
Policy Lien	\$0	Policy Lien	\$125,000	Policy Lien ²	\$135,000
Policy Loan	\$15,000	Loan Repayment	\$15,000	Policy Loan	\$0
Net Surrender Value	\$3,000	Administrative Charge	\$300	Net Surrender Value	\$0
Net Death Benefit	\$485,000	Net Payment to Owner	\$109,700	Net Death Benefit ²	\$365,000

I acknowledge that I have received and read this summary which has been furnished to me with the Policy/Rider application. This application is voluntary and without coercion on the part of any third party.

➡ Policyowner Signature _____ Date _____

➡ Agent/Producer Signature _____ Date _____

¹This example is illustrative only and is not intended to show actual values.

²Assumes death 12 months after acceleration and additional interest on lien at hypothetical 8% lien interest rate.

ACKNOWLEDGEMENT IN LIEU OF ILLUSTRATION SUBMISSION

ReliaStar Life Insurance Company of New York, Woodbury, NY
 A member of the ING family of companies
 ING Customer Service Center: PO Box 5033, Minot, ND 58702-5033



For use when no illustration is used during solicitation or when the policy applied for is different than as shown in the illustration used during solicitation.

Definition of Illustration: An illustration is written information that depicts the non-guaranteed values of a life insurance policy over a period of time greater than one year. For example, a document that shows non-guaranteed values as of age 65 would be an illustration.

I. APPLICANT *(Please select one.)*

I acknowledge that:

- No illustration was used in this solicitation.
- The illustration(s) used in this solicitation did not conform to the policy applied for.

I understand that an illustration conforming to any policy issued by ReliaStar Life Insurance Company of New York in connection with this application will be provided to me on or before delivery of the policy.

➔ Applicant Signature _____ Date _____

➔ Applicant Signature _____ Date _____

II. PRODUCER *(Please select one.)*

I certify that:

- No illustration was used in the solicitation of this application for insurance.
- The illustration(s) used in this solicitation did not conform to the policy applied for.

I have explained that any non-guaranteed elements of the policy are subject to change. I have made statements on non-guaranteed elements that are wholly consistent with the illustration that will be provided to the applicant at policy delivery.

➔ Producer Signature _____ Date _____

Producer Number _____