Group Term Life Guaranteed Issue Application

Please use this form to apply for **Guaranteed Issue** coverage during the specified enrollment period. The proposed insured should complete this application. Waiver of Premium is automatically included. *Please print clearly in dark ink and mail to: **The Bar Plan Insurance Agency, Inc., 1717 Hidden Creek Court, St. Louis, MO 63131***

The Missouri Bar **31281-9**

1. TELL US ABOUT YOURSELF

Member's Information:

Name (Last, First, M.I.)			❑ Male ❑ Female	Are you a member of The Missouri Bar? ❑ Yes ❑ No	
Date of Birth (MM/DD/YYYY)	Place of Birth (City, State)			Social Security Number	
Address		City		State	Zip
Home/Cell Phone #	Work Phone #	E-mail Address			

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

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

Name____ DOB____________________ SSN_____________________

Name____ DOB____________________ SSN_____________________

Name____ DOB____________________ SSN_____________________

Name____ DOB____________________ SSN_____________________

Address	City	State	Zip	Home/Cell Phone#

	Member
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 12 months?	❑ Yes ❑ No
b) Are you currently working less than 30 hours per week at your regular occupation and place of business?	❑ 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

*If yes, please explain:*____

2. SELECT YOUR COVERAGE

Member Amount

❑ $50,000 (Under age 50)

❑ $10,000 (Age 50-59)

Please select if you wish to include additional options with your coverage ***(if AD&D is elected, benefit will match life amount):***

❑ **Dependent Child(ren) Coverage** *(choose one)* ❑ $20,000 ❑ $15,000 ❑ $10,000 ❑ $5,000

❑ **Member Accidental Death & Dismemberment**

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. 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.

Beneficiary for Member Coverage

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

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

4. 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.

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