ReliaStar Life Insurance Company

Administrative Office: P.O. Box 122, Minneapolis, MN 55440-0122
Home Office: Minneapolis, MN
800-537-5024

SUPPLEMENTAL APPLICATION FOR LONG TERM CARE (LTC) RIDER

Section 1. Employee/Owner Information (*Must be completed)*

1. Employee's Name: _____ 2. Social Security Number: _____
3. Employer: _____

Section 2. Employee General Questions: (*Answer all questions for every proposed insured*)

	Employee Y/N	Spouse Y/N
1. Do you have another accident and sickness or long-term care insurance policy or certificate in force (including healthcare service contract, health maintenance organization contract)? Yes/No (If yes, complete Accident and Sickness or Long Term Care Insurance Replacement form.)		
2. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? Yes/No (If yes, complete Accident and Sickness or Long Term Care Insurance Replacement form.) Company Name: _____ When did policy or certificate lapse?: _____		
3. Are you covered by Medicaid?		
4. Do you intend to replace any of your medical or health insurance coverage with this rider? Yes/No (If yes, complete Accident and Sickness or Long Term Care Insurance Replacement form.)		

Section 3. Agent's Statement *(Must be completed)*

1. List any health insurance policies you have sold to the applicant that are still in force:

Company	Policy Number	Type of Coverage

2. List any other health insurance policies you have sold to the applicant in the past five (5) years that are no longer in force:

Company	Policy Number	Type of Coverage

I verify that I have truly and accurately recorded on this Supplemental Application the information supplied by the applicant.

_____ _____ _____ _____
Agent's Signature | Agent's Printed Name | Agent License Number | Date

Section 4. Applicant's Signature *(Must be completed)*

_____ _____ _____
Signed at (City & State) | on (Month, Day, Year) | Signature of Proposed Owner (Employee)

I hereby designate the following individual, in addition to myself, to receive notice of lapse or termination of coverage in the event of nonpayment of premium:

Full Name _____ Telephone _____

Home Address _____

Designation of above third party does not constitute acceptance of any liability on the third party for services provided to the insured.

WAIVER: PROTECTION AGAINST UNINTENDED LAPSE (only select if you do not wish to designate a third party)

☐ I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long Term Care Insurance Rider for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive this notice.

_____ _____ _____
Signature of Applicant | Printed Name of Applicant | Date