

Portable Life Insurance Summary for CSAC Excess Insurance Authority

Life Insurance provides basic protection for your loved ones if something happens to you. While many U.S. households have life insurance, the average amount of coverage is often inadequate to meet family needs or pay off debt. Taking advantage of life insurance coverage provided by your employer can be an important part of your financial security.

Program Basics

- In addition to the Basic Life Insurance your employer provides, eligible employees may elect more coverage by enrolling in a supplemental term life insurance program.
- This supplemental life coverage is portable. If you change jobs or retire before age 70, you can keep coverage until age 70 (may vary by state). You will be charged the same rates as active employees and spouses for the portable coverage that you elect to continue. You will be billed directly by ReliaStar for the cost of portable life coverage.
- Underwritten by ReliaStar Life Insurance Company, this program is called Portable Life.

Coverage Available

For the Employee:

- Apply for Portable Life coverage from \$10,000 to \$500,000 in \$10,000 increments.
- Provided the minimum required number of eligible employees elect coverage, you are guaranteed \$100,000 (not to exceed 5 times annual salary) of Portable Life coverage if you elect it during this enrollment period. If you apply for higher amounts of coverage, proof of good health satisfactory to ReliaStar Life must be provided.
- If the minimum required number of eligible employees do not elect coverage, or if you apply for Portable Life coverage outside of this enrollment period, proof of good health satisfactory to ReliaStar Life must be provided.
- For employees actively at work, benefit amounts reduce to 65% of original coverage at age 65 and to 50% of original coverage at age 70.
- Coverage ends at age 70 for terminated employees who have continued their coverage. Refer to your policy or certificate for provisions regarding Termination of insurance.

For the Spouse/Domestic Partner (DP):

- The spouse will need to provide proof of good health satisfactory to ReliaStar Life for coverage in excess of \$30,000.
- If you apply for higher amounts of coverage or elect it outside of your enrollment period, proof of good health satisfactory to ReliaStar Life must be provided. If the employee's spouse/DP is under age 60, he/she may apply for Portable Life coverage from \$10,000 to \$500,000 in \$10,000 increments.
- Benefit amounts reduce to 65% of original coverage at age 65 and to 50% of original coverage at age 70.

For Your Children:

- If you or your spouse/DP are covered for Portable Life, Dependent Life coverage on your children is available from \$2,000 to \$10,000 in \$2,000 increments.
- Dependent Child is defined as a child age 6 month to 19 years, or to age 25 if a full time student.
- This benefit is \$500 for children age birth to 6 months.
- Either the covered employee or spouse may apply for Dependent Life, but not both.
- If you apply for Dependent Life when you are first eligible, no proof of good health on your children is required.
- Refer to your policy or certificate for provisions regarding Eligibility and Termination of dependent's insurance.

Portable Life Insurance Rate Information

- The rate is based on your age at the start of the plan's current policy year.
- Dependent Child Life bi-weekly rate is \$.28 per \$2,000 of coverage.
- Rates shown are guaranteed 01/01/06 through 12/31/08.

PORTABLE LIFE RATE CHART (Bi-Weekly Rates/Per \$10,000 of Coverage)

Age of Employee	Employee Rate	Spouse/DP Rate
17 - 19	\$.43	\$.35
20 - 24	\$.51	\$.41
25 - 29	\$.54	\$.43
30 - 34	\$.63	\$.53
35 - 39	\$.76	\$.61
40 - 44	\$1.12	\$.90
45 - 49	\$1.80	\$1.43
50 - 54	\$3.00	\$2.39
55 - 59	\$4.46	\$3.42
60 - 64	\$6.71	\$5.58
65 - 69	\$9.61	\$7.89
70 and over	\$9.61	\$7.89

How To Use This Chart

To determine your monthly premium cost:

1. Select the total amount of Portable Life coverage you want.
2. Divide by 10,000.
3. Multiply the rate shown on the chart for your age.

Example

Ann Smith is a 35-year-old who applies for \$100,000 of Portable Life coverage.

She follows these steps for Portable Life coverage:

\$100,000 divided by 10,000 = 10

10 times .76 = 7.60

Her bi-weekly premium for \$100,000 of Portable Life coverage is \$7.60.

This is a summary of benefits only. A complete description of benefits and limitations will be provided in the certificate of coverage or policy. Policy form LP05GP, LP06GP or 45-000 (varies by state). Underwritten by ReliaStar Life Insurance Company.

Employee Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new coverage or any increases in coverage will require proof of good health if plan participation requirements are not met. Any references to coverage being obtained without proof of good health in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor County of Mendocino (CSAC Excess Insurance Authority)		Group/Plan Number 31640-7		Account Number/Location 22	
State of Employee's Primary Worksite:	Class/Occupation	Date of Hire	Annual Salary	Employment Status:	<input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time
This change is due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Late Entrant* <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Add Dependent Coverage <input type="checkbox"/> Other: _____				Effective Date of Coverage or Change:	

*A late entrant is an individual who is first enrolling for coverage after the first available opportunity.

Employee Information

Employee Name (last, first, middle initial)		<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security #	Employee I.D. #
Employee Address (street address, city, state, zip code)				Telephone Work () Home ()	

Employee Coverage Minimum amount available is \$10,000; maximum amount is \$500,000

Basic Life and AD&D	<input checked="" type="checkbox"/> Employee Only—Elect Coverage (Note: Basic Life and AD&D insurance is employer provided.)
Portable Life	Guaranteed Issue (GI) Limit = \$100,000, not to exceed 5 times annual salary. When you are first eligible for Portable Life coverage, you can elect up to the GI Limit without proof of good health. Total Portable Life coverage up to \$500,000 is available if you complete a Portable Proof of Good Health form and ReliaStar Life approves it.
Portable Life Election	I currently have Portable Life coverage of: \$ _____. I am applying for additional Portable Life coverage of: \$ _____ (\$10,000 increments) Total Portable Life coverage (current plus additional): \$ _____.

Beneficiary Information Designate your beneficiary(ies) below.

Name of Beneficiary (last name, first, middle initial)	Relationship to Employee	Benefit % (MUST total 100%)

Dependent Coverage

Dependent Life Insurance	Either you or your spouse/domestic partner may cover your dependent child(ren), but not both. When you are initially eligible for dependent coverage, you can elect it without proof of good health. At all other times, a Portable Proof of Good Health form must be completed for your child(ren) and ReliaStar Life must approve it. Children age birth to 6 months of age are covered for \$500.	
Dependent Life Insurance Election	\$ _____ (\$2,000 to \$10,000 in \$2,000 increments)	<input type="checkbox"/> Waive

Note: The covered parent is the beneficiary for any dependent child(ren) insurance coverage.

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW ▼

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed / /
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SEE OTHER SIDE

FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	LIFE	CHILD LIFE
ACCOUNT		
CLASS		
AMOUNT		
EFF. DATE		

Spouse/Domestic Partner Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Applicant. All new coverage or any increases in coverage will require proof of good health if plan participation requirements are not met. Any references to coverage being obtained without proof of good health in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor County of Mendocino (CSAC Excess Insurance Authority)		Group/Plan Number 31640-7	Account Number/Location 22
State of Employee's Primary Worksite:	Employee's Date of Hire	Employee's Employment Status:	<input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time
This change is due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Late Entrant* <input type="checkbox"/> Initial Eligibility Following Employee's Hire <input type="checkbox"/> Add Dependent Coverage <input type="checkbox"/> Other: _____		Effective Date of Coverage or Change:	

*A late entrant is an individual who is first enrolling for coverage after the first available opportunity.

Employee Information (required)

Employee Name (last, first, middle initial)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security #	Employee I.D. #
Employee Address (street address, city, state, zip code)			Telephone Work () Home ()	

Spouse/Domestic Partner (DP) Information

Name (last, first, middle initial)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security #
Address (street address, city, state, zip code)			Telephone Work () Home ()

Spouse/(DP) Coverage Minimum amount available is \$10,000; maximum amount is \$500,000

Portable Life	Guaranteed Issue (GI) Limit = \$30,000. When you are first eligible for Portable Life coverage, you can elect up to the GI Limit without proof of good health. Total Portable Life coverage up to \$500,000 is available if you complete a Portable Proof of Good Health form and ReliaStar Life approves it.
Portable Life Election	I currently have Supplemental Life coverage of: \$ _____. I am applying for additional Portable Life coverage of: \$ _____ (\$10,000 increments) Total Portable Life coverage (current plus additional): \$ _____.

Beneficiary Information Designate your beneficiary(ies) below.

Name of Beneficiary (last name, first, middle initial)	Relationship to Applicant	Benefit % (MUST total 100%)

Dependent Coverage

Dependent Life Insurance	Either you or your spouse/domestic partner may cover your dependent child(ren), but not both. When you are initially eligible for dependent coverage, you can elect it without proof of good health. At all other times, a Portable Proof of Good Health form must be completed for your child(ren) and ReliaStar Life must approve it. Children age birth to 6 months of age are covered for \$500.	
Dependent Life Insurance Election	\$ _____ (\$2,000 to \$10,000 in \$2,000 increments)	<input type="checkbox"/> Waive

Note: The covered parent is the beneficiary for any dependent child(ren) insurance coverage.

SEE OTHER SIDE

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW ▼

- Employee: I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided the employee is actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature (required)	Date Signed / /
Spouse/Domestic Partner's Signature	Date Signed / /

FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	LIFE	CHILD LIFE
ACCOUNT		
CLASS		
AMOUNT		
EFF. DATE		

Portable Proof of Good Health Form

If both employee and spouse/domestic partner are applying, they must submit SEPARATE forms.

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Applicant: If you are concerned about confidentiality, you may send this form directly to the insurance company: ReliaStar Life Insurance Company, Box 20, Route 7812, Minneapolis, MN 55440.

Name of Employer/Plan Sponsor County of Mendocino (CSAC Excess Insurance Authority)	Group/Plan Number 31640-7	Account Number/Location 22	Employee's Date of Hire
Name and phone number of the Benefits person in the Human Resources Department: Name: _____ Phone (____) _____ Ext: _____		Employee's Name (print):	
This form needed due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Late Entrant (<i>enrolling after the 1st available opportunity</i>) <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Add Dependent Coverage			
Individuals Requesting Coverage With This Form: <input type="checkbox"/> Employee OR <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Children (guaranteed) <input type="checkbox"/> Children (underwritten) <i>Note: If employee or spouse/domestic partner (not both) is applying when first eligible and coverage is approved, then the children's coverage is guaranteed. At all other times, children's coverage must be underwritten.</i>			

Employee OR Spouse/Domestic Partner Applicant Information (required)

Name (<i>last, first, middle initial</i>)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security # ____ - ____ - ____
Address (<i>street address, city, state, zip code</i>)		Telephone Work (____) _____ Home (____) _____	

Amounts Requested with this Form

Enter the **dollar** amount of current and/or guaranteed coverage. Enter the total **dollar** amount desired. The difference between these two columns is the **dollar** amount to be underwritten. For questions regarding proper amount to be underwritten, contact your Benefits person.

	Current/Guaranteed Amount	Total Amount Desired	Amount to be Underwritten
Employee: <input type="checkbox"/> Portable Life	\$ _____	\$ _____	\$ _____
OR Spouse: <input type="checkbox"/> Portable Life	\$ _____	\$ _____	\$ _____
Child(ren): <input type="checkbox"/> Dependent Life	\$ _____	\$ _____	\$ _____

Give Information Regarding Individuals Requesting Coverage With This Form

Names of persons applying with this form. <i>Please print full name.</i> (Last) (First)	Relationship to employee	Birthdate (mm/dd/yy)	Present Height (ft.) (in.)	Present Weight (pounds)	Regular physician(s) - provide name and complete mailing address (<i>attach sheet if needed</i>)
Employee	SELF				
OR Spouse/Domestic Partner					
Child					
Child					
Child					

Health Information for Employee or Spouse/Domestic Partner to be Underwritten

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you, for any condition during the past 12 months, consulted a physician, received surgical or medical care, or taken prescribed medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had, or been treated for nervous, brain or lung disorders, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury or other disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever sought help or received counseling or treatment for anxiety/depression, alcohol or drug use, or are you currently using illegal drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever applied for insurance that was declined, postponed or modified in any way? | <input type="checkbox"/> | <input type="checkbox"/> |

Health Information for Child(ren) to be Underwritten

Complete this section **only** if children must be underwritten (i.e. if coverage is **not** guaranteed).

- | | | | |
|-----|--|--------------------------|--------------------------|
| | | YES | NO |
| 6. | Is any child living away from home? If yes, state which child(ren) and their address(es): | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Has insurance applied for on any child ever been declined, postponed or modified? If yes, state which child, the reason and the date. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Has any child had or been advised to have any surgical operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Has any child ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Has any child ever had or been treated for nervous, brain or lung disorders, disorder of the immune system, asthma, heart disease or murmur, high blood pressure, ulcers, cancer, diabetes, arthritis, liver, kidney or intestinal disease, high cholesterol or triglycerides, severe injury or other disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Is each child named above now in good health and free from injury, disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered "yes" to any questions 1-5 or 8-10, or "no" to question 11, please give full details below. Attach additional sheets if needed.

Q #	Name of family member	Condition/illness/injury-type of treatment	Date of Treatment	Physician's name and complete mailing address (include the medical or clinic ID number if any)

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW ▼

- To the best of my knowledge and belief, the information I have provided on this form is complete and correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, **(Employee)** provided I am actively at work; **(Spouse/Domestic Partner)** provided I am able to carry on all the normal and customary activities of a person of like age and sex who is in good health on that date.

Authorization and Acknowledgment:

For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc.(MIB), employer or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf, ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Applicant's Signature (Employee OR Spouse/Domestic Partner) - required	Date
Signature of Parent of Proposed Insured Child (if other than applicant, AND children's coverage is not guaranteed)	Date
Signature of any Proposed Insured Child age 18 and over	Date