



# California State Firefighters' Employee Welfare Benefits Corporation (CSFEWBC)

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## Simple, Affordable & SAFE!

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### Group Term Life Insurance Application

(5-Year Age Banded Rates, 10 & 20-Year Group Level Term Rates)

## ReliaStar Life Insurance Company

Box 20 | Minneapolis, MN 55440 | Please complete and sign back of application

# Group Term Life Application

## Reference to Spouse includes Spouse or Domestic Partner

Please complete the entire application. The proposed insured should fill out this application.

*Please print clearly (black ink): Fax, Mail or Scan and E-Mail to:*

**Myers-Stevens & Toohey & Co., Inc.** | 26101 Marguerite Parkway | Mission Viejo | CA 92692  
phone 800.827.4695 | fax 949.348.2630 | CSFAinsurance@myers-stevens.com | CA Lic #0425842

## 1. Tell us about yourself

Name of Local or Association: \_\_\_\_\_ CSFA # \_\_\_\_\_

**California State Firefighters' Employee Welfare Benefits Corporation (Policy 67180-1)**

You are applying as:  Association Member  Spouse of Member

Member Name (last, first, middle)			<input type="checkbox"/> Male	<input type="checkbox"/> Active
			<input type="checkbox"/> Female	<input type="checkbox"/> Retired
Date of Birth	Height	Weight	Social Security Number	
Home Address				
City		State	ZIP	
Home Phone		Work Phone	E-mail Address	
Spouse Name (last, first, middle)			Name of Member	
Spouse Date of Birth	Spouse Height	Spouse Weight	Spouse Social Security Number	

**Indicate The Group Term Insurance Plan You Are Applying For:**

**New Academy Graduate Guaranteed Issue Group Term Life Insurance**

Date of Hire \_\_\_\_\_  \$100,000

5-Year Age Banded Rate Plan  Member  Spouse

10-Year Level Term Rate Plan  Member  Spouse

20-Year Level Term Rate Plan  Member  Spouse

➤ Indicate amount of life insurance applied for with this application

Member \$ \_\_\_\_\_ Spouse \$ \_\_\_\_\_  
*in \$50,000 increments* *in \$10,000 increments*  
 (Maximum benefit 50% of Members face amount)

- Check box to purchase:  
 \$10,000 Dependent Insurance  
 (check only if applying for dependent family coverage for the first time under this Group Policy)
- Matching Accidental Death and Dismemberment Benefit (\$500,000 Maximum Benefit)  
 Member  Yes  No Spouse  Yes  No
- Have you used tobacco products of any kind in the last 12 months?  
 Member  Yes  No Spouse  Yes  No
- Are you currently working at least 30 hours per week at your regular occupation and place of business? Member  Yes  No Spouse  Yes  No
- Will any of the insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force? If yes, please explain:  
 Member  Yes  No \_\_\_\_\_  
 Spouse  Yes  No \_\_\_\_\_

**Beneficiary Information:**

List one or more beneficiaries below. List the percent each will receive. The total must equal 100 percent. *Beneficiary for dependent coverage will be the insured under the certificate to which the dependent coverage is attached. If Spouse is applying for Group Term life insurance, the Spouse must also specify a beneficiary designation.*

Beneficiary for Member Coverage			
Name	Address	Relationship	Percent

Beneficiary for Spouse Coverage (if applying for Group Level Term coverage)			
Name	Address	Relationship	Percent

**Provide us with this health information**

- a.) Have you, for any condition during the past 12 months, consulted a physician/health practitioner, received surgical or medical care, or taken prescribed medication?  
**Member**  Yes  No      **Spouse**  Yes  No
  
- b.) Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  
**Member**  Yes  No      **Spouse**  Yes  No
  
- c.) Have you ever been diagnosed with or been treated for: disease or disorder of heart; lungs; nervous/mental system (including anxiety and depression); liver; kidneys; stomach; colon or genito-urinary system; stroke; high-blood pressure; cancer or tumor; diabetes; or arthritis?  
**Member**  Yes  No      **Spouse**  Yes  No
  
- d.) Have you ever sought help or received counseling or treatment for alcohol or drug use, or are you currently using illegal drugs?  
**Member**  Yes  No      **Spouse**  Yes  No
  
- e.) Have you ever applied for insurance that was declined, postponed or modified in anyway?  
**Member**  Yes  No      **Spouse**  Yes  No

*If you answered yes to any of the questions above, please give full details below. Attach an additional sheet if needed.*

Q#	Name	Conditions/illness/treatment	Date(s) of Treatment	Physician/Health practitioner's name and complete mailing address

f.) List the name and address of your regular physician/health practitioner and the date you last consulted with him/her:

Member \_\_\_\_\_

Spouse \_\_\_\_\_

**Read this information carefully, then sign and date below:**

- To the best of my knowledge and belief, the information I've 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.

**Authorization & Acknowledgment – Please Read & Sign Below.**

For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life 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 it's affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or it's 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

*Continued on the next page*

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.

**Any person who knowingly and with intent to defraud, submits an application or files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**

Member Signature	Print Name	Date
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Spouse Signature	Print Name	Date
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## Rates for 5-Year Age Banded Group Annual Term Life Insurance

Rates shown are guaranteed until 01/01/2014. Premiums will increase as you enter a new age bracket. Increases occur on January 1st following age change.

### Monthly Premium Rates

Coverage Amount	Under Age 30	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59*
\$50,000	2.89	3.12	3.90	5.80	8.19	12.87	23.79
\$100,000	5.77	6.24	7.80	11.70	16.38	25.74	47.58
\$150,000	8.66	9.36	11.70	17.55	24.57	38.61	71.37
\$200,000	11.54	12.48	15.60	23.40	32.76	51.48	95.16
\$250,000	14.43	15.60	19.50	29.25	40.95	64.35	118.95
\$300,000	17.32	18.72	23.40	35.10	49.14	77.22	142.74
\$350,000	20.20	21.84	27.30	40.72	57.33	90.99	166.53
\$400,000	23.09	24.96	31.20	46.80	65.52	102.96	190.32
\$450,000	25.97	28.08	35.10	52.65	73.71	115.83	214.11
\$500,000	28.86	31.20	39.00	58.50	81.90	128.70	237.90

### Rates for 10-Year Group Level Term for \$50,000 - \$1,000,000\*

Monthly Level Premium Rates per \$1,000 Rates shown are guaranteed until 01/01/2014.

### Monthly Premium

Issue Age	Non-Tobacco User	Tobacco User	Issue Age	Non-Tobacco User	Tobacco User
18-26	0.046	0.097	39	0.053	0.216
27	0.046	0.099	40	0.058	0.233
28	0.046	0.103	41	0.063	0.252
29	0.046	0.107	42	0.070	0.272
30	0.046	0.118	43	0.078	0.293
31	0.046	0.124	44	0.086	0.316
32	0.046	0.132	45	0.095	0.338
33	0.046	0.141	46	0.104	0.360
34	0.046	0.150	47	0.113	0.383
35	0.046	0.161	48	0.122	0.408
36	0.047	0.173	49	0.133	0.436
37	0.048	0.186	50	0.147	0.466
38	0.051	0.200	51	0.162	0.500

(Rates continued on next page for ages 52-60)

Rates are provided for your information and are not part of the life insurance application

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## Rates for 10-Year Group Level Term for \$50,000 - \$1,000,000\*

Monthly Level Premium Rates per \$1,000 *Rates shown are guaranteed until 01/01/2014.*

### Monthly Premium

Issue Age	Non-Tobacco User	Tobacco User	Issue Age	Non-Tobacco User	Tobacco User
52	0.180	0.536	57	0.293	0.754
53	0.199	0.575	58	0.321	0.809
54	0.222	0.617	59	0.353	0.878
55	0.245	0.662	60	0.420	1.089
56	0.268	0.707			

## Rates for 20-Year Group Level Term for \$50,000 - \$1,000,000\*

Monthly Level Premium Rates per \$1,000 *Rates shown are guaranteed until 01/01/2014.*

### Monthly Premium

Issue Age	Non-Tobacco User	Tobacco User	Issue Age	Non-Tobacco User	Tobacco User
18-26	0.051	0.112	39	0.072	0.296
27	0.053	0.118	40	0.080	0.321
28	0.054	0.124	41	0.087	0.349
29	0.054	0.133	42	0.098	0.378
30	0.054	0.146	43	0.111	0.410
31	0.055	0.157	44	0.124	0.444
32	0.056	0.169	45	0.139	0.480
33	0.057	0.182	46	0.154	0.517
34	0.058	0.197	47	0.173	0.557
35	0.059	0.214	48	0.186	0.599
36	0.061	0.232	49	0.209	0.647
37	0.063	0.251	50	0.226	0.699
38	0.068	0.273			

### AD&D Insurance

The premium rate for AD&D Insurance for you and your spouse  
is \$1.25 per \$25,000 of AD&D Insurance per month.

*\*The initial premium will not change for the first 10 or 20 years unless the insurance company exercises its right to change premium rates for all insureds under the group policy and with 60 days advance written notice.*

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