Office of the Administrator
P.O. Box 14536
Des Moines, IA 50306

Dear HSBA Member,

Thank you for inquiring about the Hawaii State Bar Association Group Insurance Program. Enclosed you'll find the information you requested for the following plan: Group Term Life Insurance Plan.

Before you take a look at the information I've enclosed, let me mention some of the important benefits you receive with all our insurance plans.

- These are group plans, negotiated especially for HSBA Members. Rates, although not scheduled, can only be changed on a group basis.

- Each plan is backed by a 30-day Free Look. After you receive your Certificate of Insurance, you have a full 30 days to review your new coverage. If you decide that it's not exactly what you want and need, simply return it. Every dollar you've paid will be refunded, and your coverage will be invalidated, no questions asked – provided no claims have been submitted or paid.

Please read the enclosed brochure for more information, including eligibility, renewability, costs, exclusions, limitations and terms of coverage on this plan.

Once you determine the type and amount of personal insurance coverage you need, simply complete and return the application in the postage-paid envelope provided. If you have questions along the way, just pick up the phone and call us. Our toll-free number is: 1-866-810-9451.

Whatever your personal situation, I hope you'll take a few minutes today to candidly assess your family's insurance needs and apply to bring your coverage up-to-date through this exclusive member program. Please return your application today!

Yours truly,

Stephen Miller

Stephen Miller, Senior Vice President
Association Member Benefits Advisors, LLC
License #1936106

P.S. Each insurance plan is offered through a well respected insurance company and every plan carries a 30-day Free Look!

(over, please)

The Hawaii State Bar receives a fee for its endorsement of the insurance programs. The fees are used to offset the cost of program oversight and support member benefits and services.
Group Term Life Insurance underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form LP08GP.

Association Member Benefits Advisors, LLC
P.O. Box 14536 ● Des Moines, IA 50306
1-866-810-9451●customerservice.service@getamba.com● www.hsbainsurance.com

66716-1-02 L1E

Group Term Life Application

Please complete the entire Application. The proposed insured should fill out this Application. Please print clearly in dark ink and mail to HSBA ***Group Insurance Program, P.O. Box 14536, Des Moines, IA 50306, or call 1-866-810-9451, or email customerservice.service@getamba.com.***

Hawaii State Bar Association	Policy No. 66716-1-02

1. TELL US ABOUT YOURSELF

Member/Employee's Information ***(complete this section only if applying for Member/Employee coverage on this application)***:

Name (Last, First, MI) ❑Member ❑Employee of Member		Name of Member	❑Male ❑Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	Email Address	

Spouse's Information ***(complete this section only if applying for Spouse coverage on this application)***:

Name (Last, First, MI) ❑Spouse of Member ❑ Spouse of Employee		Name of Member/Employee	❑Male ❑Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	Email Address	

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

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

If yes, please explain:____

PLEASE COMPLETE AND SIGN END OF APPLICATION

2. SELECT YOUR COVERAGE

Member/Employee Amount:

❑ $1,000,000

❑ $500,000

❑ $250,000

❑ Other $_____________ *in $25,000 increments (Minimum: $25,000 Maximum: $1,000,000)*

Spouse Amount:

❑ $1,000,000

❑ $500,000

❑ $250,000

❑ Other $_____________ *in $25,000 increments (Minimum: $25,000 Maximum: $1,000,000)*

Please select if you wish to include additional options with your coverage.

❑ Dependent Child(ren) Coverage*

❑ $10,000 ❑ $5,000

*If both Member/Employee and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

3. PROVIDE YOUR HEALTH INFORMATION

Member/Employee: **Height_____ft. _____in. Weight_____lbs.** Spouse: **Height_____ft. _____in. Weight_____lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member/Employee :__________________________________ Spouse:__________________________________

__________________________________ __________________________________

	Member/Employee	Spouse
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having the HIV infection or AIDS (Acquired Immunodeficiency Syndrome)?..........	❑ Yes ❑ No	❑ Yes ❑ No
2) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack), sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?..........	❑ Yes ❑ No	❑ Yes ❑ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?..........	❑ Yes ❑ No	❑ Yes ❑ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?..........	❑ Yes ❑ No	❑ Yes ❑ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?..........	❑ Yes ❑ No	❑ Yes ❑ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?..........	❑ Yes ❑ No	❑ Yes ❑ No
3) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?..........	❑ Yes ❑ No	❑ Yes ❑ No
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?..........	❑ Yes ❑ No	❑ Yes ❑ No
5) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?..........	❑ Yes ❑ No	❑ Yes ❑ No
6) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?..........	❑ Yes ❑ No	❑ Yes ❑ No

a. Member/Employee's driver's license number and state of issue:____________________________

b. Spouse's driver's license number and state of issue:____________________________

	Member/Employee	Spouse
7) Have you ever applied for insurance that was declined, postponed or modified in any way?..........	❑ Yes ❑ No	❑ Yes ❑ No
8) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?..........	❑ Yes ❑ No	❑ Yes ❑ No

PLEASE COMPLETE AND SIGN END OF APPLICATION

For every "Yes" answer to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	❑ Member/Employee ❑ Spouse				
	❑ Member/Employee ❑ Spouse				
	❑ Member/Employee ❑ Spouse				
	❑ Member/Employee ❑ Spouse				
	❑ Member/Employee ❑ Spouse				

4. 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. Attach additional sheets if necessary.

Beneficiary for Member/Employee Coverage ***(complete this section only if applying for Member/Employee coverage on this application)***

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Beneficiary for Spouse Coverage ***(complete this section only if applying for Spouse coverage on this application)***

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

PLEASE COMPLETE AND SIGN END OF APPLICATION

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

***(Choose only one. Option selected is applicable to all coverages approved through this application)*:**

❑ **Option 1:** **AUTOMATIC CHECK WITHDRAWAL REQUEST:** ❑ Monthly ❑ Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ____ ____ ____ ____ ____ ____ ____ ____ ____ Account #: ________________________

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____________________________________**Date:**_____________

❑ **Option 2:** **DIRECT BILL:** ❑ Quarterly ❑ Semi-Annual ❑ Annual

Billing dates will begin after coverage is approved and initial premium has been received.

PLEASE COMPLETE AND SIGN END OF APPLICATION

6. 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.

Authorization and Acknowledgment – Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, LLC. (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, pharmacy prescriptions or prescription records 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, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these 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 its 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 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. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life’s Consumer Privacy Notice.

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/Employee’s Signature (always required)	Date	Spouse's Signature (if applying)	Date

Owner of Member/Employee Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (First, Last, MI)		Date of Birth (MM/DD/YYYY)		Social Security Number
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature				Date

Owner of Spouse Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (First, Last, MI)		Date of Birth (MM/DD/YYYY)		Social Security Number
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature				Date

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ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, LLC., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. 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, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. 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 us. 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; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, LLC, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, LLC.

We or our reinsurers may make brief reports to MIB, LLC (hereafter "MIB"). The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

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Group Annual Term Life Insurance Plan

FOR HSBA MEMBERS, EMPLOYEES OF MEMBERS, AND THEIR FAMILIES

Group Annual Term Life Insurance is Coverage Your Family Needs

You certainly understand the importance of having sufficient life insurance. Your loved ones will appreciate the peace of mind this Plan provides, with benefits up to $1,000,000 that will let them go on with their lives with fewer financial concerns.

About This Plan

You may apply for $25,000 to $1,000,000 in Group Annual Term Life insurance coverage (in $25,000 increments). Coverage continues as long as you remain an active member of the Hawaii State Bar Association, pay your premium when due, the Group Policy remains in force, and you are under age 75.

For members/employees or spouses coverage will reduce to 50% on the premium due date on or after attainment of age 70. For members and spouses, coverage will terminate on the premium due date on or after attainment of age 75. Employees of members coverage will terminate on the last day of the month during which they were last actively at work for a member.

Eligibility

All HSBA members under age 60, and their active employees, may apply for coverage for themselves, their spouses under age 60, and their unmarried dependent children ages 14 days to 21 years (25 if a full time student).

Spouse coverage amount cannot exceed member/employee coverage amount.

If both member and their spouse are insured, either member or spouse, but not both can apply for dependent children insurance.

If both employee of member and their spouse are insured, either member or spouse, but not both can apply for dependent children insurance.

Coverage of $5,000 or $10,000 is available for your children at a monthly rate of $1.00 or $2.00, respectively. One premium covers all eligible children.

This coverage is available only to residents of the United States. Product availability may vary by state.

PLAN FEATURES

Satisfaction Guaranteed

You may return your Certificate of Insurance within 30 days if you are not completely satisfied with the coverage this Plan provides, provided no claims have been submitted or paid. Any premiums paid will be fully refunded.

Convenient Payment Options

Four modes of payment are available to suit your budget: Direct Bill Quarterly, Semiannual, and Annual, or Monthly by EFT.

If you would like to change your payment method, please contact the program administrator at 1-866-810-9451.

Beneficiary Selection

You may name anyone you wish as the beneficiary of your coverage, and you may change the beneficiary by contacting the Insurance Administrator in writing and advising them of the change.

You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

Effective Date

The Member's/Employee's/Spouse's insurance will become effective on the first day of the month on or after the later of the following dates:

- ReliaStar Life approves your proof of good health;
- Your premium is received;
- You become eligible for insurance; or
- You apply for insurance, if proof of good health is not required.

When Coverage Ends

Your insurance stops the earliest of the following dates:

- The last day of the month during which you are no longer eligible for insurance under the Group Policy.
- For members and spouses, the premium due date after the date you attain age 75.
- For employees, the last day of the month during which you were last actively at work for a member of the Policyholder.
- The date the Group Policy stops.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.

Exclusions
You're covered 365 days a year, wherever you are. The only exclusion is suicide within the first two years of the date your insurance or increase in insurance starts. The Accelerated Life Benefit is subject to additional exclusions.

OTHER IMPORTANT INFORMATION

Accelerated Life Benefit
The Accelerated Life Benefit option is available to help terminally ill insureds during a difficult, and often financially challenging, time. Under this benefit, you may request one advance payment up to 50% of your in force life insurance, or $100,000, whichever is less, to be paid while the terminally ill person is still alive. The amount of insurance payable after death will be reduced by this payment. (Premium contributions will not be reduced.)

This money can be used to help cover high prescription drug costs … medical bills … outstanding debts … to help pay for experimental treatments … the cost of modifications to your home … or for a family vacation— the choice is yours.

To qualify, a terminally ill insured must provide ReliaStar Life with a doctor's statement which give the diagnosis of the insured's medical condition and states that the insured has a life expectancy of no more than 6 months. The insured must also have at least $10,000 of life insurance coverage in force to qualify for this benefit. For additional details and limitations, please see the Certificate of Insurance.

Receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.

Waiver of Life Insurance Premium Disability Benefit
The Member/Employee or Spouse pays no premiums if he/she becomes totally disabled as defined in the Certificate. Your life insurance coverage will continue at no cost to you if you become continuously totally disabled for at least 6 months and if your disability occurs before age 60.

Hawaii State Bar Association, Group Policy 66716-1-02
GROUP ANNUAL TERM MONTHLY RATES PER $1,000

Member/Spouse/Employee of Member

	Non-Tobacco		Tobacco	
Age	$25,000 - $125,000	$150,000-$1,000,000	$25,000 - $125,000	$150,000-$1,000,000
Under 30	0.06	0.07	0.08	0.08
30-34	0.10	0.09	0.10	0.09
35-39	0.13	0.12	0.14	0.13
40-44	0.18	0.19	0.23	0.21
45-49	0.30	0.29	0.39	0.35
50-54	0.48	0.50	0.67	0.60
55-59	0.75	0.80	1.10	1.06
60-64	1.16	1.16	1.49	1.34
65-69	2.12	1.91	2.42	2.18
70-74	2.75	2.48	3.62	3.26

Rates guaranteed until June 30, 2024.

Coverage will reduce to 50% on the premium due date on or after attainment of age 70. For members and spouses, coverage will terminate on the premium due date on or after attainment of age 75. Employees of members coverage will terminate on the last day of the month during which they were last actively at work for a member.

Premiums are based on your age at date of issue and will not increase due to your health status. Premiums will only be increased if premiums are increased for all insureds in the same age and rate class. The Group Annual Term Life period begins on the effective date assigned by ReliaStar Life. To obtain a rate quote for other ages, benefit amounts, or for information on the Group Annual Term Life Plan, call toll-free 1-866-810-9451.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

About This Information

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. The complete terms and conditions of coverage are contained in Group Policy 66716-1-02, which is issued to the Hawaii State Bar Association. The group policy is sitused in the state of Hawaii and is governed by its laws.

Policy Form LP08GP

This is a Paid Endorsement. HSBA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

How to Apply

1. Complete, date and sign the Application included in the package. Be sure to indicate the coverage amount of your choice.
2. Do not send any money until ReliaStar Life Insurance Company has approved your Application and you're notified of the premium contribution due, based on the information you have provided.
3. Mail your completed Application to:
   Administrator, HSBA Group Insurance Program
   P.O. Box 14536
   Des Moines, IA 50306 or
   Email your completed Application to:
   customerservice.service@getamba.com

Administered by:

Association Member Benefits Advisors, LLC
P.O. Box 14536
Des Moines, IA 50306

QUESTIONS?
1-866-810-9451
www.hsbainsurance.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

Group AD&D Insurance Underwritten by:
ReliaStar Life Insurance Company
Minneapolis, MN

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