

# REQUEST FOR CONVERSION (NON-UNDERWRITTEN) (MT)

ReliaStar Life Insurance Company, Minneapolis, MN  
ReliaStar Life Insurance Company of New York, Woodbury, NY  
Security Life of Denver Insurance Company, Denver, CO  
Members of the *Voya*® family of companies  
(the "Company")



**Note: The effective date of the conversion will be the current month and year unless otherwise specified. The converted contract will bear the same day of the month of the original contract.**

**The suicide and incontestability periods in the converted contract will be measured from the Issue Date of the original contract, unless the converted contract contains new benefits not contained in the original contract. In this case, the suicide and incontestability provisions of the converted contract applicable to the new benefits will be measured from the date of issue of the converted contract.**

## A. CURRENT POLICY INFORMATION

Insured Name \_\_\_\_\_

Owner Name \_\_\_\_\_

Existing Policy/Certificate Number \_\_\_\_\_ Existing Company \_\_\_\_\_

**NOTE: Please complete the appropriate common life application when requesting an increase, addition of coverage, or change of premium class in connection with this conversion.**

**All conversion requests must be accompanied by a signed sales illustration.**

Convert \$ \_\_\_\_\_ of (Base/Rider Type) \_\_\_\_\_ to (Product Name) \_\_\_\_\_

**Question 1 (Select 1 checkbox):**

Continue balance of existing insurance \$ \_\_\_\_\_  Discontinue balance of existing insurance  Not applicable

**Question 2 (Select 1 checkbox):**  Refund excess premium  Apply excess premium to new policy  Not applicable

## B. REQUIREMENTS

- The converted contract must be issued to the same owner and insured as the original contract.
- **If this conversion is between Security Life of Denver Insurance Company and ReliaStar Life Insurance Company, completion of Section I (Inforce/Replacement Information) and a replacement form may be required. The notes accompanying this Request for Conversion (#127999) on Voya for Professionals include a list of states where conversions between affiliates are considered a replacement.**
- Sales Illustrations must be dated and include the names and signature of the policy owner and the agent/producer.
- When submitting an In Lieu of Illustration form, complete the applicable Accelerated Benefit Rider/Living Benefit Rider Disclosure form.
- Submit first modal premium payment. If monthly mode is selected, attach a completed EFT (#128623) and a voided check.
- Complete this Request for Conversion.

**The following sections beginning on page 2 must be completed:**

- Section D - Primary Insured Information
- Section E - Owner/Trust Information
- Section F - Policy Information
- Section G - Rider Information
- Section H - Beneficiary Information
- Section L - Agent/Producer Information

**Indexed Universal Life requires this additional section on page 4 to be completed:**

- Section J - Telephone Authorization

**Variable Life requires these additional sections on page 4 to be completed:**

- Section J - Telephone Authorization
- Section K - Suitability

**Requirements for Variable ONLY:**

- Fund Allocation of Premium Payments
- Disclosure and New Account Forms (Voya Financial Advisors, Inc. ONLY)

## C. MAILING INSTRUCTIONS

**Mail to Existing Company:**

ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York and Security Life of Denver Insurance Company  
PO Box 5075  
Minot, ND 58702-5075

**Overnight Delivery for all Companies:** Customer Service, c/o New Business, 2000 21st Ave. NW, Minot, ND 58703

**D. PRIMARY INSURED INFORMATION**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Birth Date \_\_\_\_\_ State/Country \_\_\_\_\_ Gender:  Male  Female  
SSN \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Address (PO boxes are not permitted.) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**E. OWNER/TRUST INFORMATION** (Complete if Owner is other than Primary Insured. If Owner is a Trust, please complete and submit the Trust Certification.)

1. Owner/Trust/Corporation Name \_\_\_\_\_  
2. Owner Relationship to Proposed Primary Insured \_\_\_\_\_  
3. Owner SSN/TIN \_\_\_\_\_ Owner Phone (\_\_\_\_\_) \_\_\_\_\_ Owner Birth Date \_\_\_\_\_  
4. Owner Address (PO boxes are not permitted.) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
5. Trust/Corporation Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
6. Billing Address (PO boxes are not permitted.) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
7. Type of Government Issued ID (Driver's License/Passport) \_\_\_\_\_ Document Number \_\_\_\_\_  
Issuing State or Country \_\_\_\_\_ Issuance Date \_\_\_\_\_ Expiration Date \_\_\_\_\_  
8. Trust Contact Name \_\_\_\_\_ TIN \_\_\_\_\_ Trust Date \_\_\_\_\_  
9. Trust Type:  Revocable  Irrevocable Purpose of the Trust \_\_\_\_\_  
10. Incorporation/Trust Situs State \_\_\_\_\_ Trustee/Corporate Officer Name \_\_\_\_\_  
11. Does the above trustee have sole authority to act on behalf of the trust?  Yes  No (If "No", list the names and addresses of all trustees on a separate page. All trustees must sign the application.)

**F. POLICY INFORMATION** (Must attach a copy of the illustration signed by the applicant.)

Base Face Amount (Not including Riders) \$ \_\_\_\_\_  
Payment Mode \_\_\_\_\_ Planned Scheduled Premium \_\_\_\_\_  
Death Benefit Option: (If no option is selected - default is Option A.)  A or 1-Level  B or 2-Increasing or Variable  
Death Benefit Qualification Test: (If no option is selected - default is Guideline Premium Test.)  Guideline Premium Test  Cash Value Accumulation Test  
Remaining Amount in the Term Policy: (Only applicable for partial conversions) \$ \_\_\_\_\_

**G. RIDER INFORMATION** (Check appropriate box and enter amounts. Automatic riders are not listed below. Not all riders are available with all products or in all states.)

**Signed illustration is required for permanent products.**

Waiver of Cost of Insurance Rider (only applicable if the original policy had a Waiver of Premium Rider in force at the time it was converted)  
 Other \_\_\_\_\_ \$ \_\_\_\_\_

**H. BENEFICIARY INFORMATION FOR PRIMARY AND JOINT INSURED** (If Beneficiary is a Trust, please complete and submit the Trust Certification. If Corporation, provide state of incorporation.)

Unless otherwise stated, the beneficiary designation is revocable and beneficiaries of like class shall share equally with right of survivorship.

	Name (First, MI, Last)	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN/TIN	Relationship	%	Beneficiary Type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<b>1</b>	Address				Phone ( )		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<b>2</b>	Address				Phone ( )		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<b>3</b>	Address				Phone ( )		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<b>4</b>	Address				Phone ( )		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

**I. IN FORCE/REPLACEMENT INFORMATION** (If this conversion is between Security Life of Denver Insurance Company and ReliaStar Life Insurance Company, complete this section only if the issue state is listed in the notes accompanying this form on Voya for Professionals.)

Questions 1-3 must be completed for each Proposed Insured and Owner.

	Proposed Insured		Proposed Owner	
	Yes	No	Yes	No
1. Do you currently have life insurance in force or applied for? (If "Yes," complete state required replacement form for model replacement regulation states ONLY). . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? (If "Yes," complete state required replacement form and provide details below.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? (If "Yes," complete state required replacement form and provide details below.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Insured Name	Insurance Company (Do not include group policies.)	Policy Number	Amount	Date Issued
			\$	
			\$	
			\$	
			\$	

4. Is this insurance intended to be a tax free or 1035 Exchange? (1035 not available on term insurance) . . . . .  Yes  No
5. If "Yes," will a policy loan be carried over? . . . . .  Yes  No

**J. TELEPHONE PRIVILEGES** (Complete for Indexed and Variable Products ONLY)

I understand that telephone privileges are not automatically provided to me, my agent/registered representative and his/her assistants, unless I choose those privileges. The Company may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. The Company and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be authentic. I understand that if I want to authorize telephone privileges, I must indicate below. I also understand that once granted, such privileges can be revoked only upon receipt of signed, written instructions at the Company.

I want telephone privileges.       I want telephone privileges granted to my agent/registered representative and his/her assistant.

**K. SUITABILITY/NEEDS ANALYSIS** *(Proposed Owner to complete for Variable Products ONLY)*

1. Have you received a current prospectus including supplements for the variable life insurance policy and each of the Variable Account Investment Options? . . . . .  Yes  No  
**Provide date of policy prospectus/supplement** \_\_\_\_\_
2. Do you understand that: The amount or duration of the policy death benefit may vary under specified conditions; Policy values may increase or decrease with the investment experience of the investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division; The amount payable at the final policy date is not guaranteed, but is dependent on the account value and amounts owed under the policy at that time? . . . . .  Yes  No
3. Do you understand that the fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? . . . . .  Yes  No
4. Do you understand that personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience or of actual interest credited in the Guaranteed Interest Division? . . . . .  Yes  No

**L. AGENT/PRODUCER INFORMATION** *(To be completed by the Agent/Producer. For questions about this application or requirements, contact the New Business department.)*

Agent/Producer Name/Broker-Dealer <i>(Please print.)</i>	Agent/Producer ID Number	% Split	Hierarchy ID	Hierarchy Name


Initial Payment:  Check  COD  1035 Exchange  Administrative Office Exchange/Surrender  Conversion  EFT *(at the time of issue)*  
 Age Used in Calculating Payment \_\_\_\_\_ Initial Payment \$ \_\_\_\_\_  
 Planned/Scheduled/Modal Payment \_\_\_\_\_ Amount Collected \$ \_\_\_\_\_  
 Annualized Planned Periodic Payment \_\_\_\_\_


No commission will be paid on the new policy if the term policy being converted has been sold to a life settlement company. If the new policy resulting from this conversion is settled within two years of issue, all compensation paid on this sale will be charged back. If you need a copy of your current compensation schedule applicable to this application, please contact Distributor Services at 1-877-882-5050.

**M. SIGNATURES**

**ALL WHO SIGN AGREE THAT:** No change will be made unless that policy is eligible for the change you request according to its terms or under our rules and until we are satisfied that, as of the date of this request, all Insureds and Proposed Insureds are eligible for the requested coverage.

Signed at *(City/State)* \_\_\_\_\_


 Irrevocable Beneficiary(ies) Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Must sign to authorize transaction.)*

 Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

 Owner Signature <sup>1</sup> *(if other than Insured)* \_\_\_\_\_ Date \_\_\_\_\_

Assignee Name <sup>2</sup> \_\_\_\_\_

 Assignee Signature *(if applicable)* \_\_\_\_\_ Date \_\_\_\_\_

 Agent/Producer Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent/Producer Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ Agent Email Address \_\_\_\_\_

<sup>1</sup> If the owner is a trust, partnership, or corporation, a signature is required from an officer, partner, corporate representative or authorized corporate representatives.  
<sup>2</sup> Please print full name of individual or entity. If an entity, attach corporate resolution or similar document listing authorized signatories. If entity has had a name change, include supporting documentation of successor in interest with listing of authorized signatories.