APPLICATION TO: **RELIANCE STANDARD LIFE INSURANCE COMPANY**
ADMINISTRATIVE OFFICE: **PHILADELPHIA, PENNSYLVANIA**

HOW TO APPLY:

PLEASE PRINT OR TYPE ALL INFORMATION, WITH THE EXCEPTION OF SIGNATURES.

1. **Complete Sections A and B. If you are a late enrollee or are applying for amounts over the Guaranteed Issue amount, also complete Section C.**
2. **Please sign and date the back of this application.**

A

EMPLOYER SECTION

Policyholder			Policy Number
Location	Full Time Employment Date		Class
Hours Per Week	Occupation	Salary	Hrly. Mthly. Wkly. Yrly.

EMPLOYEE SECTION

Employee's Last Name		First Name	Middle Initial
Employee's Birth Date month date year		Social Security Number	Sex Male Female
Age	State of Birth	Height	Weight
Street Address	City	State	Zip

Amount of Coverage Applied For $________________
Is this: your first application (with RSL)?
a change in amount of coverage (with RSL)? New Total Amount $___________

Beneficiary(ies) Full Name(s)	Relationship	% of Proceeds

B

Are you actively performing all the duties of your occupation or profession on a full-time basis?
Yes No IF NO, EXPLAIN.

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Is this insurance now applied for intended to replace, in whole or in part, any insurance on the life of the applicant?
Yes No IF YES, PROVIDE NAME OF COMPANY AND AMOUNT OF INSURANCE

___

C

Have… You had; been told you had/have; or been treated for any of the following within the past five years:

1 Consultation with any physician or received any medical care, treatment or advice? YES NO

2 To the best of your knowledge, any physical impairment or disease? YES NO

3 Consultation, medical care, treatment, or advice from a physician for AIDS, AIDS related complex, or disorder of the immune system? YES NO

4 A disease of the nervous, genito-urinary or digestive systems, heart or lungs, high blood pressure, diabetes cancer or a tumor of any kind? YES NO

If you answered YES to any of the questions in Section C, please give details in #5 below.

5

Question #	Illness or Nature of Injury	Date	Doctor's Full Name and Address

FOR HOME OFFICE ADMINISTRATIVE USE ONLY:

Billing Date: ______________________

SEE NEXT PAGE

- **I REPRESENT** that to the best of my knowledge and belief each of the statements and answers is complete and true. I understand that the amount of insurance for which I am applying will become effective on the date the application is approved by the Insurance Company.

- **I CERTIFY** that I am an employee of he sponsoring organization and otherwise meet the eligibility requirements for applying for this insurance.

- **I AUTHORIZE** my employer to deduct premium contributions required to be made by me from my salary as consideration for insurance on me issued by RELIANCE STANDARD LIFE INSURANCE COMPANY. I understand coverage will be effective as stated above, provided premiums are paid and service waiting periods are satisfied, as applicable. I authorize you to adjust these deductions based on underwriting changes, or rate changes resulting from age changes. During the continuance of this agreement, my employer will forward the premium to the Insurance Company as it falls due. This authorization may be revoked by me by written notice to my employer.

- **I ACKNOWLEDGE** receipt of the "Notice Regarding Information Practices".

- **I AUTHORIZE** any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the Medical Information Bureau (MIB) to release any information or records(s) on me or my health to be used in determining the acceptability of my application for insurance. I authorize any such information or record (s) to be released to Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize Reliance Standard Life Insurance Company or its reinsurers to make a brief report to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I may elect to be interviewed if an investigative consumer report is to be prepared in connection with this application and that I am entitled to a copy there of. I further understand that I am entitled to receive a copy of this Authorization upon request.

- **Please review the front of the application for completeness before signing. Incomplete sections may cause coverage to be delayed or declined.**

Signature X______________________________ ______________________________

Applicant Date

- **REQUEST TO WAIVE COVERAGES OFFERED**

  I certify that I have been advised of the features and benefits of the program offered to me through my employer and have decided not to participate.

______________________________ ______________________________

EMPLOYEE SIGNATURE DATE

RELIANCE STANDARD LIFE INSURANCE COMPANY