Reliance Standard Life Insurance Company
Enrollment and Statement of Health
DO NOT WRITE IN THESE BOXES

Name of Employer County of Champaign		Location/Division		Bill Group 000001
Policy # and Class # GL153919 / 01	Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #

Application Type: ☐ Initial Eligibility/New Hire ☐ Late Applicant ☐ Other _____
☐ Increase ☐ Approved Annual Enrollment
☐ Change in Status: Nature of Change(s): _____

Date of Change: _____
If marriage, domestic partnership, divorce, dissolution of a partnership, or birth of a child, please provide copy of document.

Employee/Member Information – Always Complete

Submit completed Enrollment and Statement of Health form to:
EOIApplications@rsli.com or

Reliance Standard
P.O. Box 7818
Philadelphia, PA 19101-7818

We do not accept faxed forms.

Name				Social Security Number/Employee ID
Gender	Date of Birth	Age	State of Birth	Date of Hire
Address		City	State	Zip
Phone Number	Occupation	Annual Compensation	Hours Worked Per Week	
Email Address				

Are you actively performing all the duties of your occupation or profession? ☐ Yes ■ No

If "No," explain: _____

Spouse Information – Complete Only If Applying for Spouse Coverage

Spouse Name	Gender	Date of Birth	Age	State of Birth
Address	City	State	Zip	

Coverage Elected and Amounts

Coverage	Enroll or Decline[1]	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Group Term Basic Life and AD&D Employee[2]	Enroll	N/A	N/A	$20,000	Employer Paid
Group Term Supplemental Life Employee[2]	☐ Enroll ☐ Decline		Choose one:	☐ $200,000 ☐ $150,000 ☐ $100,000 ☐ $50,000 ☐ $10,000 ☐ Other$_____	See Premium Table
Group Term Life: Spouse[2,3]	☐ Enroll ☐ Decline		Choose One:	☐ $30,000 ☐ $25,000 ☐ $20,000 ☐ $15,000 ☐ $10,000 ☐ Other$_____	See Premium Table
Group Term Life: Dep. Children[3]	☐ Enroll ☐ Decline		Choose One:	☐ $10,000	$1.00

[1]"Enroll" authorizes employer to payroll deduct premiums.
[2]Statement of Health may be required.
[3]Coverage subject to election of employee coverage.

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Designation of Beneficiary

Policyholder	Policy Number(s)
Insured Name	Social Security Number

I hereby designate the following as my beneficiary (ies) under the above policy number(s):
Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally between all contingent beneficiaries.

- This beneficiary designation revokes all revocable prior beneficiary designations.
- Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class (primary or contingent).
- If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured