Reliance Standard Life Insurance Company
Enrollment and Statement of Health

Name of Employer	Location/Division	Bill Group
San Luis Obispo County Office of Education		000001

Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #
VCI864565 / 01	VAI864562 / 01	VHI864563 / 01		

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" includes domestic partner.)

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

Answer the following questions only if applying for Critical Illness Insurance.

Are the following individuals currently covered by insurance that provides benefits for hospital and medical services and supplies?

Employee? ☐ Yes ☐ No Spouse? ☐ Yes ☐ No Children*? ☐ Yes ☐ No

If the employee answers "No", then no policy will be issued. If the employee has coverage but the Spouse and/or Children* do not, those Individuals without such coverage will not be covered under the Critical Illness policy.

*ALL children must have insurance that provides benefits for hospital and medical services and supplies to be eligible for dependent coverage under the Critical Illness policy; otherwise, no children will be covered.

Coverage Elected and Amounts

Coverage	Enroll or Decline[1]	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Voluntary Critical Illness: Employee	☐ Enroll ☐ Decline			☐ $10,000 ☐ $20,000	See Premium Table
Voluntary Critical Illness: Spouse[2,3]	☐ Enroll ☐ Decline			☐ $10,000 ☐ $20,000	See Premium Table
Voluntary Critical Illness: Dependent Child(ren)[3]	☐ Enroll ☐ Decline			25% of Employee Amount	See Premium Table

Employee/Member Name	Date of Birth

Coverage Elected and Amounts

Coverage	Enroll or Decline[1]	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Voluntary Accident: Select only **one** Option	☐ Enroll ☐ Decline			☐ Plan B: Employee ☐ Plan B: Employee + Spouse ☐ Plan B: Employee + Child(ren) ☐ Plan B: Employee + Family	See Premium Table
Voluntary Hospital: **Select only one Plan And Option**	☐ Enroll ☐ Decline			☐ Standard: Employee ☐ Standard: Employee + Spouse ☐ Standard: Employee + Child(ren) ☐ Standard: Employee + Family	See Premium Table

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

Clients using Online Billing and Enrollment: Dependent child coverage requires one dependent child record including first name, last name and date of birth. If multiple dependent children are covered, only 1 dependent child record is required. If you do not have the dependent child's information, enter the First Name as "Child" and use the employee's Last Name and employee's Date of Birth to add dependent child coverage.

Read, Sign and Date Below

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next.
- If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices".

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the MIB, Inc. to release any information or record(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 or its reinsurers to make a brief report of my personal health information 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 (or my authorized representative) will be sent a copy of this Authorization upon request.

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable,) have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

X _____ _____ Employee's/Member's Signature (required at all times) Date	X _____ _____ Spouse's Signature (required if spouse Statement of Health required) Date