Reliance Standard Life Insurance Company
Enrollment and Statement of Health

Name of Employer		Location/Division		Bill Group
Nyemaster Goode, P.C.		1		000001
Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #
VPL302886 / 1				

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, divorce 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
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: _____

Coverage Elected and Amounts

Coverage	Enroll or Decline[1]	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Voluntary LTD: Employee[2]	£ Enroll £ Decline			£ 60% of Earnings to $5,000 max.	See Premium Table

"Earnings" as used above refers to "Covered Earnings" as defined in the applicable Policy.
[1]"Enroll" authorizes employer to payroll deduct premiums.
[2]Statement of Health may be required.

Employee/Member Name	Date of Birth

Health Questions

Answer all questions on this page for each person being underwritten for insurance. For any "Yes" answer, underline the condition and record details in the space provided on the next page. Failure to provide details of a condition will cause a delay in the review of your application.

	EMPLOYEE
Enter height and weight.	Ht. __ft. ___in. Wt. _____ lbs
1. In the past 10 years, have you been treated for or diagnosed as having: heart, liver (biliary cirrhosis) or kidney disorder; an abnormal colonoscopy requiring follow-up; neurological disorder; diabetes; high blood pressure; thyroid disorder; stroke; transient ischemic attack (TIA); cancer and/or tumor malignant or benign; mental or nervous disorder; or been advised to have treatment for drug abuse (illegal or prescription drugs) or alcoholism?	£ Yes £ No
2. In the past 10 years, have you been diagnosed with or treated for: chronic pain; arthritis (lupus, rheumatoid or osteoarthritis); musculoskeletal (back, neck or muscle) condition; respiratory disorder including asthma, chronic obstructive pulmonary disease (COPD); or emphysema?	£ Yes £ No
3. Have you: (a) in the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); or lymphadenopathy (enlarged or swollen glands)? or (b) in the past 10 years ever tested positive or been treated for HIV (Human Immunodeficiency Virus) antibodies, AIDS or AIDS-related complex (ARC)?	£ Yes £ No
4. In the past 10 years, have you: (a) consulted with or been examined or treated by a physician, practitioner or specialist (include routine physicals only when there is an existing or newly diagnosed medical condition)? (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation? or (c) been prescribed medication(s) (other than for colds, flu or allergies)?	£ Yes £ No
5. Are you currently pregnant? In the past 10 years, have you been diagnosed with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	£ Yes £ No

Employee/Member Primary Care Physician's Full Name	Office Phone Number
Address	

Employee/Member Name	Date of Birth

Details

Please provide all names used for medical records (if different than the names provided on this form):_____

_____

For each "Yes" response to a health question, please provide details below.

Question #	Illness or Nature of Injury	Date	Physician's Full Name and Address (if different than Primary)

If you need more space, check here £. Complete, sign and date a separate sheet of paper and attach it to this page.

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 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; or b) during your present service with your employer or an affiliate, you 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