

# Reliance Standard Life Insurance Company

## Enrollment and Statement of Health

Name of Employer American Sales & Management Organization LLC dba Eulen			Location/Division		Bill Group 000001
Policy # and Class # VGTL186747 / 01	Policy # and Class # LTD130324 / 01	Policy # and Class # VCI802657 / 01, 02	Policy # and Class # VAR207711 / 01	Policy # and Class # VAI827909 / 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](mailto: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 a domestic partner.)

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

### Child Information – Complete Only If Applying for Child Coverage ("Child" includes all children of a domestic partnership.)

Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No

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

### Coverage Elected and Amounts

Coverage	Enroll or Decline <sup>1</sup>	Current Amount	Increase or Decrease	Total Amount Applied For	Premium
<b>Voluntary Term Life: Employee<sup>2</sup></b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$ _____	See Premium Table
<b>Voluntary Term Life: Spouse<sup>2</sup></b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$ _____	See Premium Table
<b>Voluntary Term Life: Dep Children</b> (Coverage subject to election of employee or spouse Term Life)	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$ _____	See Premium Table

Employee/Member Name	Date of Birth
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### Coverage Elected and Amounts

Coverage	Enroll or Decline <sup>1</sup>	Current Amount	Increase or Decrease	Total Amount Applied For	Premium
<b>Group Long Term Disability</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> 60% of Earnings to \$1,200 max.	See Premium Table
<b>Voluntary Critical Illness: Employee</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$_____	See Premium Table
<b>Voluntary Critical Illness: Spouse<sup>2,3</sup></b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$_____	See Premium Table
<b>Voluntary Critical Illness: Dependent Child(ren)<sup>3</sup></b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			25% of Employee Amount	See Premium Table
<b>Voluntary AD&amp;D: Employee</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$_____	See Premium Table
<b>Voluntary AD&amp;D: Spouse</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$_____	See Premium Table
<b>Voluntary AD&amp;D: Dep. Child(ren)</b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$_____	See Premium Table
<b>Voluntary Accident:</b> Select only <b>one</b> Option	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> Plan B: Employee <input type="checkbox"/> Plan B: Employee + Spouse <input type="checkbox"/> Plan B: Employee + Child(ren) <input type="checkbox"/> Plan B: Employee + Family	See Premium Table

"Earnings" as used above refers to "Covered Earnings" as defined in the applicable Policy.

<sup>1</sup>"Enroll" authorizes employer to payroll deduct premiums.

<sup>2</sup>Statement of Health may be required.

<sup>3</sup>Coverage subject to election of employee coverage.

Employee/Member Name	Date of Birth
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## 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.

This Section applies to:

- 1) late applicants;
- 2) those electing a benefit increase\* or a benefit amount over the guaranteed issue amount;
- 3) any person who has had a previous application for Reliance Standard coverage rejected and is re-applying\*\*
- 4) any person who has had a previous Reliance Standard coverage voluntarily terminated and wishes to have coverage again\*\*.

\*Unless the benefit increase is during an open enrollment period

\*\*In both cases, a person must answer the health questions, even during an open enrollment period.

	EMPLOYEE	SPOUSE
<b>Enter height and weight.</b>	Ht. ___ft. ___in. Wt. ___lbs	Ht. ___ft. ___in. Wt. ___lbs
1. In the past 10 years, have you or your spouse been treated for or diagnosed by a licensed medical provider as having: heart, liver (hepatitis or 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 10 years, have you or your spouse been diagnosed by a licensed medical provider 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); cystic fibrosis or emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or your spouse: (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) (b) in the past 10 years ever tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection; or been diagnosed by a licensed medical provider as having AIDS-related complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 10 years, have you or your spouse: (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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 10 years, have you or your spouse been diagnosed by a licensed medical provider with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer only if you are applying for short term disability/VPS:</b> Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 10 years, have you or your spouse been diagnosed or treated by a licensed medical provider for Alzheimer's Disease, dementia, Parkinson's or motor neuron diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer question 7 only if applying for Critical Illness insurance.</b>		
7. To the best of your knowledge and belief, have two or more of your or your spouse's biological parents, brothers or sisters (either living or dead) been diagnosed by a licensed medical provider with the same condition from the following list of conditions: diabetes, heart disease, stroke, kidney disease or cancer (other than skin cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee/Member Name		Date of Birth	
Employee/Member Primary Care Physician's Full Name		Office Phone Number	
Address			
Spouse Primary Care Physician's Full Name		Office Phone Number	
Address			

### 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.

**DO NOT PROVIDE ANY DETAILS FOR A "YES" ANSWER TO QUESTION 3(b).**

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

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 (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, LLC. 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.

I understand that I may revoke this Authorization at any time by writing to Reliance Standard Life at its Administrative Office (address: 1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938 Attn: Medical Underwriting). I understand that revocation is subject to the rights of any person who acted in reliance of this Authorization prior to Reliance Standard Life receiving written notice of the revocation. I further understand that renovation of this Authorization will not apply to Reliance Standard when the law provides for the right to contest the insurance coverage or a claim thereunder.

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.

<input checked="" type="checkbox"/> _____ Employee's/Member's Signature (required at all times)	_____	<input checked="" type="checkbox"/> _____ Spouse's Signature (required if spouse Statement of Health required)	_____
Date		Date	

Licensed Florida Agent Maria Teresa Fuentes

Licensed Florida Agent Number 581417

## Important Information Regarding Applications for Insurance

The information provided on the Enrollment and Statement of Health form will be used in determining the insurability of a person proposed for insurance. Responsible parties completing and submitting a Statement of Health form are required to be made aware of the following statements concerning the consequences of insurance fraud. The lack of an applicable statement shall not constitute a defense against penalties.

**ALABAMA, ARKANSAS and LOUISIANA** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **COLORADO** — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **FLORIDA** — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **KENTUCKY** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **MAINE** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MARYLAND** — Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **MASSACHUSETTS** — Any person who knowingly presents a false or fraudulent claims for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NEW JERSEY** — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NEW MEXICO** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NEW YORK** (health insurance only) — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **OHIO** — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **PENNSYLVANIA** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties. **RHODE ISLAND** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **TENNESSEE, VIRGINIA, and WASHINGTON** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **WASHINGTON, DC** — WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**KEEP THIS INFORMATION PAGE FOR YOUR RECORDS.**



Home Office: Schaumburg, Illinois  
Administrative Office: Philadelphia, Pennsylvania

## NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, Reliance Standard Life Insurance Company ("we", "us" or "our") collects certain information about all proposed insureds ("you" or "your"). The precise information varies according to the amount and type of coverage you apply for. Generally, we seek information about you: (1) age; (2) occupation; (3) physical condition; (4) medical history; (5) hobbies; and (6) other relevant activities.

You are the most important source of information, but we may also verify or collect information on you or your family from: (1) physicians; (2) other health care providers; (3) employers; (4) other insurers to which you have applied; (5) consumer investigative organizations; and (6) the MIB, LLC.

The MIB is a not-for-profit organization of life insurance companies which operates an information exchange for its members. This information may alert us to a need for further investigation, but under MIB rules such information cannot be used: (1) either wholly or in part to increase the premium for insurance; or (2) to deny issuance of insurance.

We may collect information by: (1) phone; (2) correspondence; or (3) personal contact.

Information will be treated as confidential. Reliance Standard Life Insurance Company or its reinsurers may, however, with your authorization make a brief report to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. The information supplied to other member companies may alert them to a need for further investigation.

In some circumstances, however, information may be released to third parties without your authorization (with the exception of the MIB). These include persons or organizations who are: (1) performing business functions for us; (2) conducting actuarial or scientific studies or audits; or (3) our reinsurers. We or our reinsurers may also release information to other life insurance companies to whom you apply for life or health insurance coverage, or to whom a claim for benefits is submitted. Please be assured that although such disclosures may occur, they are not always or even often made. When a disclosure is necessary, only as much information as is reasonably necessary to achieve the intended purpose will be disclosed.

You have the right to acquire and, if necessary, correct any personal information we or the MIB collect. Upon written request to us, we will within 30 days of receipt: (1) inform you of the nature and substance of the recorded information; (2) permit personal viewing and copying of the information in our possession; (3) disclose the identities of those persons such information has been disclosed to within the last two years; and (4) provide you with procedures for correction, amendment or deletion of the recorded information. Medical information will be disclosed to a physician that you choose. You may write to us for a fuller explanation of our information practices.

You may also contact the MIB via its website ([www.mib.com](http://www.mib.com)) or by telephone to arrange for disclosure of any information it may have on you. The MIB's toll-free telephone number is 866-692-6901. If you question the accuracy of information in the MIB's file, you may contact the MIB in writing and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

## KEEP THIS NOTICE FOR YOUR RECORDS.



**Home Office: Schaumburg, Illinois**  
**Administrative Office: Philadelphia, Pennsylvania**