

RELIANCE STANDARD

Life Insurance Company

Enrollment/Change Form

Please print and complete all sections. See instructions below.

EMPLOYER INFORMATION

Employer Name	Group Number	Location (City, State)	Effective Date
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EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number
Home Street Address		City/State/Zip		Home Phone ()		Work Phone ()
Amount of Earnings \$ _____ <input type="checkbox"/> Hr. <input type="checkbox"/> Wk. <input type="checkbox"/> Mo. <input type="checkbox"/> Yr.		Full-Time Employment Date ____ MO. ____ Day ____ Yr.		Employee's Occupation: _____		Employee Insurance Amount: \$ _____

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number	Insurance Amount
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number	Insurance Amount
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number	Insurance Amount

Beneficiary For Employee

<input type="checkbox"/> A <input type="checkbox"/> C	Primary Contingent	Last Name _____ _____	First Name _____ _____	M.I. _____ _____	AGE _____ _____	Relationship to Employee _____ _____
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Benefits will be paid first to the Primary Beneficiary(ies). If that person(s) is deceased, benefits will be paid to the Contingent Beneficiary(ies). (Legal appointment of guardian is required if minor is named as beneficiary.) If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

The Insured Spouse's and Insured Child's beneficiary is the Employee. If the Employee is not living on the date of the Insured Spouse's or Insured Child's death, the beneficiary is the Employee's estate.

Instructions

Employer name: Legal name of the employer.
Group Number: Provided by RSL or RSL representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with RSL proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name (Provide Insured's or Beneficiary's former Name), employee address or employee phone.

Employee Signature: _____

Date: _____