First Reliance Standard Life Insurance Company Enrollment and Statement of Health for Group Insurance

Submit completed Enrollment and Statement of Health form to: **EOIApp**

Receipt of accelerated death be	enefits under Lif	e Insurance ma	y affect eligibility f	or public assistance programs and may	be taxable.
Coverage	Enroll or Decline ¹	Current Amount	Increase or Decrease	Total Amount Applied For	Premium
Group Term Life: Dep. Children ³	Enroll Decline			\$5,000	See Premium Table
Voluntary AD&D: Employee	Enroll Decline			Times Earnings	See Premium Table
Voluntary AD&D: Spouse	Enroll Decline			\$10,000	See Premium Table

Employee/Member Name	Date of Birth

Coverage Elected and Amounts

Receipt of accelerated death benefits under Life Insurance may affect eligibility for public assistance programs and may be taxable. Disability Insurance pre-existing conditions provision/limitation: if your disability is related to a pre-existing condition, benefits may be limited or no benefits may be payable depending on the length of your disability.

Coverage	Enroll or Decline ¹	Current Amount	Increase or Decrease	Total Amount Applied For	Premium
Voluntary AD&D: Dep. Child(ren)	Enroll Decline			\$5,000	See Premium Table

[&]quot;Earnings" as used above refers to "Covered Earnings" as defined in the applicable Policy.

1"Enroll" authorizes employer to payroll deduct premiums.

2Statement of Health may be required.

Clients using Online Billing and Enrollment: Dependent chi

³Coverage subject to election of employee coverage.

Employee/Member Name

Employee/Member Name		Date of Birth					
Details							
Please prov	ide all names used for medical record	ds (if different th	an the names provided on this form):				
For each "Yes	s" response to a health question, please	provide details be	elow				
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

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 and belief.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy and Certificate; any amount subject to evidence of insurability will not become effective until approved by First Reliance Standard and First 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 and Certificate.
- For age-banded rate plans, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next.

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 First Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of the "Designation of Beneficiary" form and "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices". If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy and Certificate will determine to whom benefits, if any, will be payable.

Please Note: Certain war risks are not assumed. In case of any doubt, contact First Reliance Standard for further explanation.

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 excluding psychotherapy notes and records relating to drug and alcohol treatment to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to First Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize First 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 First Reliance Standard at its Administrative Office (address: 1700 Market St, 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 First Reliance Standard when the law provides for the right to contest the insurance coverage or a claim there under.

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 First 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

Applicable to 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 (\$5,000) and the stated value of the claim for each such violation.

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

Administrative Office: 1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938 Home Office: 590 Madison Avenue, 29th Floor, New York, New York 10022

FRSL-9457-0918



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.

NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, First 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 your: (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. First Reliance Standard Life Insurance Company or its reinsurers may, however, with your authorization