

A Applicant's Name (First-Middle-Last) Male
 Female

Address _____

City _____ State _____ Zip _____

Birthdate _____ Age _____ State of Birth _____ Soc. Sec. No. _____

Height _____ Weight _____ Occupation _____ Date Hired _____

Amount of Coverage Applied For \$ _____

- Initial Application (with RSL)
 Change in Amount of Coverage (with RSL)
Total Amount with Change \$ _____

Name of Beneficiary and Relationship

B Are you actively performing all the duties of your occupation or profession? YES NO
IF NO, EXPLAIN.

Have you used tobacco in any form in the past twelve months? YES NO

Is this insurance now applied for intended to replace, in whole or in part, any insurance on the life of the applicant, spouse or dependent children? YES NO

IF YES, PROVIDE NAME OF COMPANY AND AMOUNT OF INSURANCE.

Guaranteed Issue Amounts -

Initial Enrollment or Newly Eligible:
Employee Under Age 60: \$60,000.00
Employee Age 60 to 70: \$10,000.00
Spouse Under Age 60: \$20,000.00 (provided the employee applies for at least \$50,000.00)

D Spouse's Name (First-Middle-Last) Male Female

Address _____

City _____ State _____ Zip _____

Birthdate _____ Age _____ State of Birth _____ Height _____ Weight _____

Has your spouse used tobacco in any form in the past twelve months? YES NO

Amount of Coverage Applied For \$ _____

- Initial Application (with RSL)
 Change in Amount of Coverage (with RSL)
Total Amount with Change \$ _____

Eligible Dep. Children Coverage: YES NO
If Dependent Children are to be covered, please select an amount below:

All children age 14 days to 6 months: \$1,000

All children age 6 months to 26 years:

\$2,500 \$5,000 \$7,500 \$10,000

Name of Beneficiary: (Unless otherwise listed below, Employee is automatically the Beneficiary for Spouse and Dependent Children Insurance.)

Name of Beneficiary and Relationship

HOW TO APPLY:

COMPLETE IN INK. PLEASE PRINT OR TYPE ALL INFORMATION, WITH THE EXCEPTION OF SIGNATURES.

- For the Guaranteed Issue Amount, complete **Sections A and B.**
- If you desire coverage in excess of the Guaranteed Issue Amount, or you are a late enrollee, complete **Sections A, B and C.**
- If you desire coverage on your spouse only and/or your children, complete all Sections of the application.
- Please sign and date the back of this application.**
- Return the application to your personnel office for processing.

NOTE: Coverage is available for domestic partners of eligible employees who have an "Affidavit of Domestic Partnership" on file with the School District of Litchfield. The word "spouse", as it appears in this application, will be deemed to include "domestic partner".

C Have...You or your spouse had; been told you had/have; or been treated for any of the following within the past five years:

1 Consultation with any physician or received any medical care, treatment or advice? YES NO

3 AIDS, AIDS related complex, or disorder of the immune system? YES NO

2 To the best of your knowledge, any physical impairment or disease? YES NO

4 A disease of the nervous, genito-urinary or digestive systems, heart or lungs, high blood pressure, diabetes, cancer or a tumor of any kind? YES NO

If you answered YES to any of the questions in Section C, give details in #5 below.

5 Question #	Person to Whom It Applies	Illness or Nature of Injury	Date	Doctor's Full Name and Address

FOR HOME OFFICE ADMINISTRATIVE USE ONLY:

Billing Date _____

- **I REPRESENT** that to the best of my knowledge and belief each of the statements and answers is complete and true. I understand that the guaranteed amount of insurance for which I am applying will become effective on: (1) the latter of (a) the date the application is signed or (b) July 1, 2005, for employees employed prior to July 1, 2005; or (2) the first day of the month following the date the application is signed, for employees employed on or after July 1, 2005. I further understand that any amount of insurance for which I am applying which is above the guaranteed amount will be effective on: (1) the latter of (a) the date the application is approved by the Insurance Company or (b) July 1, 2005, for employees employed prior to July 1, 2005; or (2) the first day of the month following the date the application is signed, provided the Insurance Company agrees to insure me, for employees employed on or after July 1, 2005.
- **I CERTIFY** that I am an employee of the sponsoring organization or otherwise meet the eligibility requirements for applying for this insurance.
- **I AUTHORIZE** my employer to deduct the applicable premium from my salary as consideration for Term Life Insurance on me and/or my family issued by RELIANCE STANDARD LIFE INSURANCE COMPANY. I understand coverage will be effective as stated above, provided premiums are paid and service waiting periods are satisfied, as applicable. I authorize you to adjust these deductions based on underwriting changes, or rate changes resulting from age changes. During the continuance of this agreement, my employer will forward the premium to the Insurance Company as it falls due. This authorization may be revoked by me by written notice to my employer.
- **I ACKNOWLEDGE** receipt of the "Notice Regarding Information Practices".
- **I AUTHORIZE** any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the Medical Information Bureau (MIB) 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 Life Insurance Company or its reinsurers to make a brief report 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 may elect to be interviewed if an investigative consumer report is to be prepared in connection with this application and that I am entitled to a copy thereof. I further understand that I am entitled to receive a copy of this Authorization upon request.
- **PLEASE NOTE:** During an open enrollment, applications for amounts of insurance up to the guaranteed issue limit will not require medical evidence provided this application is complete, signed and received by your employer during the open enrollment and the applicant was not previously declined for insurance coverage by Reliance Standard Life Insurance Company, postponed, had an application withdrawn or voluntarily terminated insurance with Reliance Standard Life Insurance Company.
- **Please review the front of the application for completeness before signing. Incomplete sections may cause coverage to be delayed or declined.**

Signature	X		
	Applicant		Date
	X		
	Spouse (only if coverage on spouse is requested)		Date

• **REQUEST TO WAIVE COVERAGES OFFERED**

I certify that I have been advised of the features and benefits of the program offered to me through my employer and have decided not to participate.

EMPLOYEE SIGNATURE	DATE
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