Plan Highlights

Supplemental and Dependent Life Insurance

Community Physical Therapy & Associates, Ltd. - Class 2

ELIGIBILITY

Each Active Full-time Employee not in another eligble class working 30 or more hours per week, except any person working on a temporary or seasonal basis.

Dependents: You must be insured in order for Dependents to be covered.

Dependents are:

- your legal spouse not legally separated or divorced from you
- your unmarried financially dependent children* age 14 days to 20 years (to 26 years if full-time student).

*natural and adopted children; stepchildren and foster children in your custody.

Age limit does not apply to handicapped children.

- A person may not have coverage as both an Employee and Dependent.
- Only one insured spouse may cover Dependent children.

BENEFIT AMOUNT

Supplemental Life and AD&D

Choose from a minimum of $10,000 to a maximum of $250,000 in $10,000 increments

Flat amounts of life insurance equal to $150,000 or more may be subject to an earnings cap.

Dependent Life

Spouse

Choose from a minimum of $5,000 to a maximum of $125,000 in $5,000 increments

(spouse amount may not exceed 50% of employee amount)

Dependent Child(ren)

choice of $1,000; $5,000 or $10,000

GUARANTEED ISSUE (INITIAL ELIGIBILITY PERIOD ONLY)

Employee: $100,000

Spouse: $50,000

Child: all child amounts are guaranteed issue

CONTRIBUTION REQUIREMENTS

Basic Life (and AD&D):

Coverage is 100% employer paid.

Supplemental Life and AD&D:

Coverage is 100% employee paid.

Dependent Life:

Spouse: Coverage is 100% employee paid.

Dependent Child(ren): Coverage is 100% employee paid.

AD&D SCHEDULE

For Accidental Loss of:	Amount Payable:
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
Speech and hearing	100%
One hand or One foot	50%
Sight of one eye	50%
Speech or Hearing	50%

BENEFIT REDUCTION DUE TO AGE (applicable to employee/spouse coverage)

Age	Original Benefit Reduced To
70	50%

RATE

See attached Rate Sheet.

FEATURES

- Accelerated Death Benefit (expressed as Living Benefit Rider in some states and Imminent Death Benefit in PA)
- Air Bag Benefit
- Conversion Privilege
- FMLA/MSLA Continuation
- Seat Belt Benefit
- Waiver of Premium with Critical Illness

VALUE ADDED SERVICES

- Bereavement Counseling Service

EXCLUSIONS

AD&D EXCLUSIONS:

AD&D benefits will not be payable for a loss: caused by suicide or intentionally self-inflicted injuries; caused by or resulting from war or any act of war, declared or undeclared; to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor;

sustained during an insured's commission or attempted commission of an assault or felony; to which the insured's acute or chronic intoxication is a contributing factor; or to which the insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6422, et al.

Reliance Standard Plans
Supplemental Life and AD&D and Dependent Life Insurance
Premium Table

Plan Holder: Community Physical Therapy & Associates, LTD.

Scheduled Benefit: Each eligible employee may elect for himself and/or his eligible spouse an amount of insurance shown in the Table below.

For employees age 70 and older: Benefit amounts are reduced according to the age-based reduction chart shown in the Supplemental Life brochure. Employee/Spouse Premiums:

To find you and your spouse's premium -

- Determine your age band: Your age = your age at your last birthday.
- Select a benefit amount (employees age 70 and older: see above comment).
- Spouse premium: Repeat the steps above for your spouse at your age at your last birthday.
- Employee and spouse rates change as insured moves from one age bracket to the next.

Employee Monthly Premiums

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70-74	Age 75+
$10,000	$0.46	$0.72	$0.98	$1.24	$2.02	$2.80	$4.88	$9.04	$13.20	$22.30	$39.70	$146.80
$20,000	$0.92	$1.44	$1.96	$2.48	$4.04	$5.60	$9.76	$18.08	$26.40	$44.60	$79.40	$293.60
$30,000	$1.38	$2.16	$2.94	$3.72	$6.06	$8.40	$14.64	$27.12	$39.60	$66.90	$119.10	$440.40
$40,000	$1.84	$2.88	$3.92	$4.96	$8.08	$11.20	$19.52	$36.16	$52.80	$89.20	$158.80	$587.20
$50,000	$2.30	$3.60	$4.90	$6.20	$10.10	$14.00	$24.40	$45.20	$66.00	$111.50	$198.50	$734.00
$60,000	$2.76	$4.32	$5.88	$7.44	$12.12	$16.80	$29.28	$54.24	$79.20	$133.80	$238.20	$880.80
$70,000	$3.22	$5.04	$6.86	$8.68	$14.14	$19.60	$34.16	$63.28	$92.40	$156.10	$277.90	$1,027.60
$80,000	$3.68	$5.76	$7.84	$9.92	$16.16	$22.40	$39.04	$72.32	$105.60	$178.40	$317.60	$1,174.40
$90,000	$4.14	$6.48	$8.82	$11.16	$18.18	$25.20	$43.92	$81.36	$118.80	$200.70	$357.30	$1,321.20
$100,000	$4.60	$7.20	$9.80	$12.40	$20.20	$28.00	$48.80	$90.40	$132.00	$223.00	$397.00	$1,468.00
$110,000	$5.06	$7.92	$10.78	$13.64	$22.22	$30.80	$53.68	$99.44	$145.20	$245.30	$436.70	$1,614.80
$120,000	$5.52	$8.64	$11.76	$14.88	$24.24	$33.60	$58.56	$108.48	$158.40	$267.60	$476.40	$1,761.60
$130,000	$5.98	$9.36	$12.74	$16.12	$26.26	$36.40	$63.44	$117.52	$171.60	$289.90	$516.10	$1,908.40
$140,000	$6.44	$10.08	$13.72	$17.36	$28.28	$39.20	$68.32	$126.56	$184.80	$312.20	$555.80	$2,055.20
$150,000	$6.90	$10.80	$14.70	$18.60	$30.30	$42.00	$73.20	$135.60	$198.00	$334.50	$595.50	$2,202.00
$160,000	$7.36	$11.52	$15.68	$19.84	$32.32	$44.80	$78.08	$144.64	$211.20	$356.80	$635.20	$2,348.80
$170,000	$7.82	$12.24	$16.66	$21.08	$34.34	$47.60	$82.96	$153.68	$224.40	$379.10	$674.90	$2,495.60
$180,000	$8.28	$12.96	$17.64	$22.32	$36.36	$50.40	$87.84	$162.72	$237.60	$401.40	$714.60	$2,642.40
$190,000	$8.74	$13.68	$18.62	$23.56	$38.38	$53.20	$92.72	$171.76	$250.80	$423.70	$754.30	$2,789.20
$200,000	$9.20	$14.40	$19.60	$24.80	$40.40	$56.00	$97.60	$180.80	$264.00	$446.00	$794.00	$2,936.00
$210,000	$9.66	$15.12	$20.58	$26.04	$42.42	$58.80	$102.48	$189.84	$277.20	$468.30	$833.70	$3,082.80
$220,000	$10.12	$15.84	$21.56	$27.28	$44.44	$61.60	$107.36	$198.88	$290.40	$490.60	$873.40	$3,229.60
$230,000	$10.58	$16.56	$22.54	$28.52	$46.46	$64.40	$112.24	$207.92	$303.60	$512.90	$913.10	$3,376.40
$240,000	$11.04	$17.28	$23.52	$29.76	$48.48	$67.20	$117.12	$216.96	$316.80	$535.20	$952.80	$3,523.20
$250,000	$11.50	$18.00	$24.50	$31.00	$50.50	$70.00	$122.00	$226.00	$330.00	$557.50	$992.50	$3,670.00

Spouse Monthly Premiums

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69
$5,000	$0.26	$0.39	$0.52	$0.78	$1.04	$1.69	$2.99	$5.72	$7.08	$14.04
$10,000	$0.52	$0.78	$1.04	$1.56	$2.08	$3.38	$5.98	$11.44	$14.16	$28.08
$15,000	$0.78	$1.17	$1.56	$2.34	$3.12	$5.07	$8.97	$17.16	$21.24	$42.12
$20,000	$1.04	$1.56	$2.08	$3.12	$4.16	$6.76	$11.96	$22.88	$28.32	$56.16
$25,000	$1.30	$1.95	$2.60	$3.90	$5.20	$8.45	$14.95	$28.60	$35.40	$70.20
$30,000	$1.56	$2.34	$3.12	$4.68	$6.24	$10.14	$17.94	$34.32	$42.48	$84.24
$35,000	$1.82	$2.73	$3.64	$5.46	$7.28	$11.83	$20.93	$40.04	$49.56	$98.28
$40,000	$2.08	$3.12	$4.16	$6.24	$8.32	$13.52	$23.92	$45.76	$56.64	$112.32
$45,000	$2.34	$3.51	$4.68	$7.02	$9.36	$15.21	$26.91	$51.48	$63.72	$126.36
$50,000	$2.60	$3.90	$5.20	$7.80	$10.40	$16.90	$29.90	$57.20	$70.80	$140.40
$55,000	$2.86	$4.29	$5.72	$8.58	$11.44	$18.59	$32.89	$62.92	$77.88	$154.44
$60,000	$3.12	$4.68	$6.24	$9.36	$12.48	$20.28	$35.88	$68.64	$84.96	$168.48
$65,000	$3.38	$5.07	$6.76	$10.14	$13.52	$21.97	$38.87	$74.36	$92.04	$182.52
$70,000	$3.64	$5.46	$7.28	$10.92	$14.56	$23.66	$41.86	$80.08	$99.12	$196.56
$75,000	$3.90	$5.85	$7.80	$11.70	$15.60	$25.35	$44.85	$85.80	$106.20	$210.60
$80,000	$4.16	$6.24	$8.32	$12.48	$16.64	$27.04	$47.84	$91.52	$113.28	$224.64
$85,000	$4.42	$6.63	$8.84	$13.26	$17.68	$28.73	$50.83	$97.24	$120.36	$238.68
$90,000	$4.68	$7.02	$9.36	$14.04	$18.72	$30.42	$53.82	$102.96	$127.44	$252.72
$95,000	$4.94	$7.41	$9.88	$14.82	$19.76	$32.11	$56.81	$108.68	$134.52	$266.76
$100,000	$5.20	$7.80	$10.40	$15.60	$20.80	$33.80	$59.80	$114.40	$141.60	$280.80
$105,000	$5.46	$8.19	$10.92	$16.38	$21.84	$35.49	$62.79	$120.12	$148.68	$294.84
$110,000	$5.72	$8.58	$11.44	$17.16	$22.88	$37.18	$65.78	$125.84	$155.76	$308.88
$115,000	$5.98	$8.97	$11.96	$17.94	$23.92	$38.87	$68.77	$131.56	$162.84	$322.92
$120,000	$6.24	$9.36	$12.48	$18.72	$24.96	$40.56	$71.76	$137.28	$169.92	$336.96
$125,000	$6.50	$9.75	$13.00	$19.50	$26.00	$42.25	$74.75	$143.00	$177.00	$351.00

Dependent Children Premiums: *One rate and benefit amount for all eligible children in family, regardless of number*

Benefit Amount	Premium
$1,0 00	$0.18
$5,000	$0.91
$10,000	$1.82

Rates are subject to change.

Plan Highlights

Voluntary Group Long Term Disability Insurance

Community Physical Therapy

COVERAGE

Disability income protection insurance provides a benefit for "long term" disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY

Each Active, Full-Time Community Physical Therapy employee working 30 or more hours per week, and earning an annual salary of at least $15,000, except any person working on a temporary or seasonal basis.

BENEFIT AMOUNT

You may elect a monthly benefit in increments of $100, from a minimum of $500 up to a maximum benefit of $5,000 per month, not to exceed 60% of your covered earnings (rounded to the next lower increment).

ELIMINATION PERIOD

90 consecutive days of total disability

MAXIMUM BENEFIT DURATION

Benefits will not extend beyond the longer of: Social Security Normal Retirement Age or Duration of Benefits below:

Age at Disablement	Duration of Benefits
61 or less	to age 65
62	3 ½ years
63	3 years
64	2 ½ years
65	2 years
66	1 ¾ years
67	1 ½ years
68	1 ¼ years
69 or more	1 year

CONTRIBUTION REQUIREMENTS

Coverage is 100% employee paid.

You are required to contribute toward the cost of this insurance. Your contributions are being made on a post-tax basis. This means that (under the law as of the date the policy was issued) your Monthly Benefit may be treated as non-taxable for the purposes of filing your Federal Income Tax Return. It is recommended that you contact your personal tax advisor.

RATES

See attached Rate Sheet.

FEATURES

- FMLA Continuation
- Own Occupation Coverage – 24 months
- Rehabilitation provision
- Residual and Partial Disability
- Specific Indemnity Benefit
- Survivor Benefit – 3 months
- Work Incentive & Child Care provisions

VALUE ADDED SERVICES

- Travel Assistance Service

LIMITATIONS

- Limited Benefit Period for Other Specific Conditions – 24 months
- Mental/Nervous Illness Limitation – 24 Months out-patient
- Offsets (such as, but not limited to, Social Security, Workers Compensation, State Disability Plans)
- Pre-Existing Condition Limitation – 3/12
- Substance Abuse Limitation – 24 Months

Please note- pre-ex limitations also apply to benefit increases

EXCLUSIONS

Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony;injury or sickness occurring while confined in any penal or correctional institution.

For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6564, et al.

Reliance Standard Voluntary Plans
Voluntary Group Long Term Disability Insurance
Premium Table
Plan Holder: Community Physical Therapy & Associates, Ltd - VPL # 301272

Scheduled Benefit: Each eligible employee may elect an amount of insurance, in increments of $100 from a minimum of $500 to a maximum of $5,000 per month up to 60% of covered earnings.

You may select any benefit amount from $500 up to your maximum monthly benefit. Locate your annual earnings to determine your maximum monthly benefit amount. If your covered earnings fall between ranges, the lesser benefit amount will apply.

Employee Monthly Premiums

Annual Earnings	Monthly Benefit Amount	Age -19	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$15,000	$500	$1.45	$1.45	$2.15	$2.90	$3.75	$5.50	$8.85	$12.05	$15.55	$17.10	$25.00	$27.30
$15,000	$600	$1.74	$1.74	$2.58	$3.48	$4.50	$6.60	$10.62	$14.46	$18.66	$20.52	$30.00	$32.76
$15,000	$700	$2.03	$2.03	$3.01	$4.06	$5.25	$7.70	$12.39	$16.87	$21.77	$23.94	$35.00	$38.22
$16,000	$800	$2.32	$2.32	$3.44	$4.64	$6.00	$8.80	$14.16	$19.28	$24.88	$27.36	$40.00	$43.68
$18,000	$900	$2.61	$2.61	$3.87	$5.22	$6.75	$9.90	$15.93	$21.69	$27.99	$30.78	$45.00	$49.14
$20,000	$1,000	$2.90	$2.90	$4.30	$5.80	$7.50	$11.00	$17.70	$24.10	$31.10	$34.20	$50.00	$54.60
$22,000	$1,100	$3.19	$3.19	$4.73	$6.38	$8.25	$12.10	$19.47	$26.51	$34.21	$37.62	$55.00	$60.06
$24,000	$1,200	$3.48	$3.48	$5.16	$6.96	$9.00	$13.20	$21.24	$28.92	$37.32	$41.04	$60.00	$65.52
$26,000	$1,300	$3.77	$3.77	$5.59	$7.54	$9.75	$14.30	$23.01	$31.33	$40.43	$44.46	$65.00	$70.98
$28,000	$1,400	$4.06	$4.06	$6.02	$8.12	$10.50	$15.40	$24.78	$33.74	$43.54	$47.88	$70.00	$76.44
$30,000	$1,500	$4.35	$4.35	$6.45	$8.70	$11.25	$16.50	$26.55	$36.15	$46.65	$51.30	$75.00	$81.90
$32,000	$1,600	$4.64	$4.64	$6.88	$9.28	$12.00	$17.60	$28.32	$38.56	$49.76	$54.72	$80.00	$87.36
$34,000	$1,700	$4.93	$4.93	$7.31	$9.86	$12.75	$18.70	$30.09	$40.97	$52.87	$58.14	$85.00	$92.82
$36,000	$1,800	$5.22	$5.22	$7.74	$10.44	$13.50	$19.80	$31.86	$43.38	$55.98	$61.56	$90.00	$98.28
$38,000	$1,900	$5.51	$5.51	$8.17	$11.02	$14.25	$20.90	$33.63	$45.79	$59.09	$64.98	$95.00	$103.74
$40,000	$2,000	$5.80	$5.80	$8.60	$11.60	$15.00	$22.00	$35.40	$48.20	$62.20	$68.40	$100.00	$109.20
$42,000	$2,100	$6.09	$6.09	$9.03	$12.18	$15.75	$23.10	$37.17	$50.61	$65.31	$71.82	$105.00	$114.66
$44,000	$2,200	$6.38	$6.38	$9.46	$12.76	$16.50	$24.20	$38.94	$53.02	$68.42	$75.24	$110.00	$120.12
$46,000	$2,300	$6.67	$6.67	$9.89	$13.34	$17.25	$25.30	$40.71	$55.43	$71.53	$78.66	$115.00	$125.58
$48,000	$2,400	$6.96	$6.96	$10.32	$13.92	$18.00	$26.40	$42.48	$57.84	$74.64	$82.08	$120.00	$131.04
$50,000	$2,500	$7.25	$7.25	$10.75	$14.50	$18.75	$27.50	$44.25	$60.25	$77.75	$85.50	$125.00	$136.50
$52,000	$2,600	$7.54	$7.54	$11.18	$15.08	$19.50	$28.60	$46.02	$62.66	$80.86	$88.92	$130.00	$141.96
$54,000	$2,700	$7.83	$7.83	$11.61	$15.66	$20.25	$29.70	$47.79	$65.07	$83.97	$92.34	$135.00	$147.42
$56,000	$2,800	$8.12	$8.12	$12.04	$16.24	$21.00	$30.80	$49.56	$67.48	$87.08	$95.76	$140.00	$152.88
$58,000	$2,900	$8.41	$8.41	$12.47	$16.82	$21.75	$31.90	$51.33	$69.89	$90.19	$99.18	$145.00	$158.34
$60,000	$3,000	$8.70	$8.70	$12.90	$17.40	$22.50	$33.00	$53.10	$72.30	$93.30	$102.60	$150.00	$163.80
$62,000	$3,100	$8.99	$8.99	$13.33	$17.98	$23.25	$34.10	$54.87	$74.71	$96.41	$106.02	$155.00	$169.26
$64,000	$3,200	$9.28	$9.28	$13.76	$18.56	$24.00	$35.20	$56.64	$77.12	$99.52	$109.44	$160.00	$174.72
$66,000	$3,300	$9.57	$9.57	$14.19	$19.14	$24.75	$36.30	$58.41	$79.53	$102.63	$112.86	$165.00	$180.18
$68,000	$3,400	$9.86	$9.86	$14.62	$19.72	$25.50	$37.40	$60.18	$81.94	$105.74	$116.28	$170.00	$185.64
$70,000	$3,500	$10.15	$10.15	$15.05	$20.30	$26.25	$38.50	$61.95	$84.35	$108.85	$119.70	$175.00	$191.10
$72,000	$3,600	$10.44	$10.44	$15.48	$20.88	$27.00	$39.60	$63.72	$86.76	$111.96	$123.12	$180.00	$196.56
$74,000	$3,700	$10.73	$10.73	$15.91	$21.46	$27.75	$40.70	$65.49	$89.17	$115.07	$126.54	$185.00	$202.02

Employee Monthly Premiums

Annual Earnings	Monthly Benefit Amount	Age -19	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$76,000	$3,800	$11.02	$11.02	$16.34	$22.04	$28.50	$41.80	$67.26	$91.58	$118.18	$129.96	$190.00	$207.48
$78,000	$3,900	$11.31	$11.31	$16.77	$22.62	$29.25	$42.90	$69.03	$93.99	$121.29	$133.38	$195.00	$212.94
$80,000	$4,000	$11.60	$11.60	$17.20	$23.20	$30.00	$44.00	$70.80	$96.40	$124.40	$136.80	$200.00	$218.40
$82,000	$4,100	$11.89	$11.89	$17.63	$23.78	$30.75	$45.10	$72.57	$98.81	$127.51	$140.22	$205.00	$223.86
$84,000	$4,200	$12.18	$12.18	$18.06	$24.36	$31.50	$46.20	$74.34	$101.22	$130.62	$143.64	$210.00	$229.32
$86,000	$4,300	$12.47	$12.47	$18.49	$24.94	$32.25	$47.30	$76.11	$103.63	$133.73	$147.06	$215.00	$234.78
$88,000	$4,400	$12.76	$12.76	$18.92	$25.52	$33.00	$48.40	$77.88	$106.04	$136.84	$150.48	$220.00	$240.24
$90,000	$4,500	$13.05	$13.05	$19.35	$26.10	$33.75	$49.50	$79.65	$108.45	$139.95	$153.90	$225.00	$245.70
$92,000	$4,600	$13.34	$13.34	$19.78	$26.68	$34.50	$50.60	$81.42	$110.86	$143.06	$157.32	$230.00	$251.16
$94,000	$4,700	$13.63	$13.63	$20.21	$27.26	$35.25	$51.70	$83.19	$113.27	$146.17	$160.74	$235.00	$256.62
$96,000	$4,800	$13.92	$13.92	$20.64	$27.84	$36.00	$52.80	$84.96	$115.68	$149.28	$164.16	$240.00	$262.08
$98,000	$4,900	$14.21	$14.21	$21.07	$28.42	$36.75	$53.90	$86.73	$118.09	$152.39	$167.58	$245.00	$267.54
$100,000	$5,000	$14.50	$14.50	$21.50	$29.00	$37.50	$55.00	$88.50	$120.50	$155.50	$171.00	$250.00	$273.00

Reliance Standard Life Insurance Company
Enrollment and Statement of Health

Name of Employer Community Physical Therapy & Associates			Location/Division	
Policy # and Class # VPL301272 / 1	Policy # and Class # GL153418 / 02	Policy # and Class #	Policy # and Class #	Bill Group 100001

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: ______________________

Spouse Information – Complete Only If Applying for Spouse Coverage

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

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		+$_______per Month -$_______per Month	$________per Month	See Premium Table
Group Term Supplemental Life and AD&D Employee[2]	☐ Enroll ☐ Decline		+$___________ -$___________	$___________	See Premium Table
Group Term Life: Spouse[3]	☐ Enroll ☐ Decline		+$___________ -$___________	$___________	See Premium Table
Group Term Life: Dep. Children[3]	☐ Enroll ☐ Decline		+ $__________ - $__________	☐ $1,000 ☐ $5,000 ☐ $10,000	$0.18 $0.91 $1.82

[1]"Enroll" authorizes employer to payroll deduct premiums.
[2]Statement of Health may be required.
[3]Coverage subject to election of employee coverage.

Clients using Online Billing and Enrollment: Dependent child coverage requires one dependent child record including first name, last name and date of birth. If multiple dependent children are covered, only 1 dependent child record is required. If you do not have the dependent child's information, enter the First Name as "Child" and use the employee's Last Name and employee's Date of Birth to add dependent child coverage.

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	**SPOUSE**
Enter height and weight.	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 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	☐ Yes ☐ No
2. In the past 10 years, have you or your spouse 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	☐ Yes ☐ 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)? or (b) in the past 10 years ever tested positive or been treated or diagnosed by a physician for HIV (Human Immunodeficiency Virus) antibodies, AIDS or AIDS-related complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ 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)?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you currently pregnant? In the past 10 years, have you or your spouse been diagnosed with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	☐ Yes ☐ No	☐ Yes ☐ No

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

Spouse 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)	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 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 will determine to whom benefits, if any, will be payable.

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 (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.

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

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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.

Date	Signature of Insured

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 Heath 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.

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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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, 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.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Home Office: Chicago, 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 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, Inc.

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) 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.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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