APPLICATION TO: ADMINISTRATIVE OFFICE:

RELIANCE STANDARD LIFE INSURANCE COMPANY PHILADELPHIA, PENNSYLVANIA

	Α	Policy	nolder						Poli	cy Numbe	r		
HOW TO APPLY:	N S	Location Full Time			Full Time Emp	nployment Date			Class				
PLEASE PRINT OR TYPE ALL INFORMATION, WITH THE EXCEPTION OF SIGNATURES.	EMPLOYER SECTION	Hours Per Week Occu			ccupation	upation			☐ Hrly. ☐ Mthly. ☐ Wkly. ☐ Yrly.				
		Employee's Last Name				First Name			Middle Initial				
1.Complete Sections A and B. If you are a late enrollee or are applying for amounts over the Guaranteed Issue	EMPLOYEE SECTION	Employee's Birth Date month date year			year	Social Security Number			,			lale emale)
			Age State of Birth Street Address			Height			Weight Zip				
				Δ	onlied For \$	City			laic		Ζίρ		
amount, also complete Section C.		Amount of Coverage Applied For \$											
2.Please sign and date the back of this application.	-	Beneficiary(ies) Full Name(s)				Relationship % of Proceeds							
3. Return the application to your personnel office for processing.	В	Are you actively performing all the duties of your occupation or profession on a full-time basis? □Á/es □ No IF NO, EXPLAIN.											
4. You can submit the application to eoiapplications@rsli. com.		Is this insurance now applied for intended to replace, in whole or in part, any insurance on the life of the applicant? # # # *Yes No IF YES, PROVIDE NAME OF COMPANY AND AMOUNT OF INSURANCE											
	С	Have You had; been told you had/have; or been treated for any of the following within the past five years:											
		1 Consultation with any physician □ YES or received any medical care, □ NO treatment or advice? □ NO □ YES □ NO □ To the best of your knowledge, any □ YES □ NO □ Physical impairment or disease? □ NO □ N											
		3 AID: disor	YES NO	4 A disease of the nervous, genito- ☐ YES urinary or digestive systems, heart ☐ NO or lungs, high blood pressure, diabetes cancer or a tumor of any kind?									
		If you answered YES to any of the que 5 Question Illness or Nature of Injury				· •			se give details in #5 below. Doctor's Full Name and Address				
FOR HOME OFFICE A	DMINIS	STRATIV	E USE ONLY	<u>/:</u>									

SEE NEXT PAGE

Billing Date:

LRS-8774-0793

SmartChoice

- I REPRESENT that to the best of my knowledge and belief each of the statements and answers is complete and true. <u>I</u> understand that the amount of insurance for which I am applying will become effective on the date the application is approved by the Insurance Company.
- I CERTIFY that I am an employee of the sponsoring organization and otherwise meet the eligibility requirements for applying for this insurance.
- I AUTHORIZE my employer to deduct premium contributions required to be made by me from my salary as consideration for insurance on me 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 records(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 of my (our) personal health information to the MIB. This authorization, or a photographic copy, shall be 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 review the front of the application for completeness before signing. Incomplete sections may cause

Signature X______Applicant 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

RELIANCE STANDARD LIFE INSURANCE COMPANY

LRS-8774-0793 SmartChoice

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

A MEMBER OF THE TOKIO MARINE GROUP

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