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

Name of Employer The Resource Center - Chautauqua County ARC		Location/Division		Bill Group 000001
Policy # and Class # GL158243 / 1	Policy # and Class # VPL302643 / 1	Policy # and Class # VPS327619 / 1	Policy # and Class #	Policy # and Class #

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

First 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

- When Life Insurance coverage includes accelerated death benefits: receipt of accelerated death benefits under Life Insurance may effect eligibility for public assistance programs and may be taxable.
- If Disability Insurance coverage includes a pre-existing conditions provision/limitation and 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	Bi-Weekly Premium
Group Term Supplemental Life Employee[2]	☐ Enroll ☐ Decline			☐ $20,000 ☐ $40,000 ☐ $80,000 ☐ $120,000 ☐ $140,000 ☐ Other$________	See Premium Table
Group Term Life: Spouse[2,3]	☐ Enroll ☐ Decline			☐ 50% of Employee Supplemental Benefit	See Premium Table
Group Term Life: Dep. Children[3]	☐ Enroll ☐ Decline			☐ $1,000 ☐ $2,000 ☐ $5,000 ☐ $7,000 ☐ $10,000 ☐ Other$________	See Premium Table
Voluntary LTD: Employee[2]	☐ Enroll ☐ Decline			☐ 50% of Earnings to $7,500 max.	See Premium Table

Employee/Member Name	Date of Birth

Coverage Elected and Amounts

- When Life Insurance coverage includes accelerated death benefits: receipt of accelerated death benefits under Life Insurance may effect eligibility for public assistance programs and may be taxable.
- If Disability Insurance coverage includes a pre-existing conditions provision/limitation and 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	Bi-Weekly Premium
Voluntary STD: Employee[2]	☐ Enroll ☐ Decline			☐ 60% of Earnings to $2,000 max.	See Premium Table

"Earnings" as used above refers to "Covered Earnings" as defined in the applicable Policy.
[1]"Enroll" authorizes employer to payroll deduct premiums.
[2]Statement of Health may be required.
[3]Coverage subject to election of employee 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 been diagnosed or treated for 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	

FRSL-9457-0114

Administrative Office: 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090
Home Office: 590 Madison Avenue, 29th Floor, New York, New York 10022

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 and belief.
- 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 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 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, Inc. 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: 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090 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 receiving written notice of the revocation. I further understand that revocation of this Authorization will not apply 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/Member's Signature (required at all times)	Date	Spouse's Signature (required if spouse Statement of Health required)	Date

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Home Office: 590 Madison Avenue, 29th Floor, New York, New York 10022