EVIDENCE OF INSURABILITY

Reliance Standard Life Insurance Company Home Office—Chicago, Illinois
Administrative Office—Philadelphia, Pennsylvania

INSTRUCTIONS:

Employer:

- **Complete Policy No., eligibility date, hire date, employer name/address and completed by sections and give to employee/member to complete the rest.**
- **Mail the form to:**
  RELIANCE STANDARD LIFE INSURANCE COMPANY
  Medical Underwriting Department
  2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090

Employee/Member:

- **Enter information requested for yourself and/or each dependent to be insured.**
- **Answer each health question "yes" or "no" or the form will be returned.**
- **Return the form to your employer to be forwarded to Reliance Standard Life Insurance Company**

Name of Employee/Member: Social Security No.: Address: Home Telephone Number: E-mail:	Policy No. Reason for Evidence and Amount Applied For:

Hire Date	Eligibility Date:	If approved, coverage will become effective as of the date indicated below, provided: (1) the employee was actively at work; and (2) dependents were not hospital or home confined on that date.

This Evidence For:

☐ Employee/Member only
☐ Dependents only
☐ Employee/Member & Dependents

Employer's Name & Address

Completed by: *(Name & Title)*

FOR RELIANCE STANDARD LIFE USE ONLY:

NOTICE OF ACTION The following action has been taken with respect to the evidence of insurability submitted by the:

Employee/Member:	__Approved	__ Declined	__Incomplete
Spouse:	__Approved	__ Declined	__Incomplete
Child:	__ Approved	__ Declined	__Incomplete

Effective Date if Approved:

Date

Names Of Proposed Insureds	Occupation	Annual Salary	Gender	Date Of Birth	Place Of Birth	Height	Weight
Self:							
Spouse: Social Security No.:							
Unmarried Dependent Children: (use separate sheet for additional dependents)							

1. Have you or any Proposed Insured been diagnosed or treated for any of the following within the past 5 years: (Underline the condition and record details in space provided.)

	Yes	No
a. Eye or ear: disease; disorder; or impairment?	☐	☐
b. Diabetes; goiter; tumor; cancer; or growth of any kind?	☐	☐
c. Rheumatism; arthritis; gout; spine; or back trouble?	☐	☐
d. Disease of the nervous system; mental or emotional disorder; dizziness; loss of consciousness; convulsions; or epilepsy?	☐	☐
e. Asthma; tuberculosis; or any disease of the lungs or respiratory system?	☐	☐
f. Heart disease; rheumatic fever; or heart murmur?	☐	☐
g. High blood pressure; heart attack; or chest pain?	☐	☐
h. Stomach or duodenal ulcer; indigestion; or any disease or disorder of the: stomach; intestines; rectum; liver; or gall bladder?	☐	☐
i. Hernia; hemorrhoids; varicose veins; disease of the blood vessels; anemia; or other blood disorder?	☐	☐
j. Kidney colic or stone; syphilis; or any disease of the kidney or bladder?	☐	☐
k. Sugar; albumin; blood; or pus in the urine?	☐	☐
l. Deformity; joint disorder; or physical impairment?	☐	☐
m. AIDS; AIDS related complex; or disorder of the immune system?	☐	☐
n. Disease or disorder of the genital; and/or reproductive organs?	☐	☐
o. Been diagnosed or treated for excessive use of: alcohol; tobacco; or habit-forming drug?	☐	☐

2. Are you or any Proposed Insured currently pregnant? ☐ ☐

3. Other than the above, have you or any Proposed Insured, within the past 5 years:

a. Had an electrocardiogram; x-ray; or other special test?	☐	☐
b. Been consulted; treated; or examined by any physician or practitioner for any reason not previously mentioned?	☐	☐
c. Been operated on, or advised to have any operation?	☐	☐
d. Had a physical check-up?	☐	☐
e. Been postponed; rated up or declined for Life; Hospitalization; Major Medical; or Accident and Sickness Insurance?	☐	☐
f. Made claim for or received benefits or pension due to any injury or illness?	☐	☐

4. *Name, address and phone number of primary care physician*: _____

_____

If any question is answered "Yes," give details below. Also, show name and address of attending physician(s) if other than listed in 4. above.

Question #	Person to whom it applies	Illness or Nature of Injury	Date	Physician's Name and Address

_____

_____

_____

_____

_____

_____

_____

_____

(add separate sheet if additional space is needed)

AGREEMENT

I represent that to the best of my knowledge and belief that each of the above statements and answers are complete and true. I understand that the insurance applied for will not become effective until this Application has been approved by Reliance Standard Life Insurance Company and only in accordance with the provisions of the Policy**. I 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 will be without expense to Reliance Standard Life Insurance Company and that I will be responsible for paying the expenses, if any.**

AUTHORIZATION—I hereby 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 (us) or my (our) health. I authorize any such information or record(s) to be released to Reliance Standard Life Insurance Company or its reinsurers. 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 binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I (we) may elect to be interviewed if an investigative consumer report is to be prepared in connection with my (our) application and that I am (we are) entitled to a copy thereof. I further understand that I am (we are) entitled to receive a copy of this Authorization upon request.

WARNING: It is a crime to provide false of 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.

I acknowledge receipt of the “Notice Regarding Information Practices.”

DATE SIGNED _____ SIGNATURE OF EMPLOYEE/MEMBER _____

DATE SIGNED _____ SIGNATURE SPOUSE (if spouse is requesting coverage) _____

NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, Reliance Standard Life Insurance Company (herein referred to as we, us or our) collects certain information about all proposed insureds (herein referred to as you, your or yours). 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 Medical Information Bureau (herein referred to as MIB).

The MIB is a non-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, 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 MIB). These include persons or organizations who are: (1) performing business functions for us; (2) conducting actuarial or scientific studies or audits; (3) our reinsurers; or (4) other insurers to which you have applied. 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 requests to us, we will, within thirty (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 directly by writing to Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660 to arrange for disclosure of any information on you. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.