

**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. <hr/> Reason for Evidence and Amount Applied For:
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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.
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This Evidence For:  <input type="checkbox"/> Employee/Member only <input type="checkbox"/> Dependents only <input type="checkbox"/> Employee/Member & Dependents	<b>FOR RELIANCE STANDARD LIFE USE ONLY:</b> <b>NOTICE OF ACTION</b> 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
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<b>Employer’s Name &amp; Address</b>   Completed by: <i>(Name &amp; Title)</i>	Effective Date if Approved: <hr/> Signed – Group Underwriter  Date
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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 by a physician for any of the following within the past 5 years: (Underline the condition and record details in space provided.)

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

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?	<input type="checkbox"/>	<input type="checkbox"/>	e. Been postponed; rated up or declined for Life; Hospitalization; Major Medical; or Accident and Sickness Insurance?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been consulted; treated; or examined by any physician or practitioner for any reason not previously mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	f. Made claim for or received benefits or pension due to any injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been operated on, or advised to have any operation?	<input type="checkbox"/>	<input type="checkbox"/>			
d. Had a physical check-up?	<input type="checkbox"/>	<input type="checkbox"/>			

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 to be used in determining the acceptability of my (our) application for insurance. 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.

I acknowledge receipt of the "Notice Regarding Information Practices."

DATE SIGNED \_\_\_\_\_

SIGNATURE OF EMPLOYEE/MEMBER \_\_\_\_\_

DATE SIGNED \_\_\_\_\_

SIGNATURE OF SPOUSE (if spouse is requesting coverage) \_\_\_\_\_