

ENROLLMENT APPLICATION

EMPLOYER: We do not accept faxed forms. Submit completed enrollment applications for insurance to:
 SETSEG - Enrollment
 415 W. Kalamazoo St.
 Lansing, MI 48933-2079

Mid Michigan Community College
 Policy Number: VG 648564
 Policy Number: VAR 648814

BG 000001
 RSO Michigan
 VG GI: \$30,000/\$10,000/\$20,000/No

All sections must be completed to ensure accurate processing. PRINT IN BLUE OR BLACK INK.

▼ EMPLOYEE INFORMATION ▼

Reason for Completing Form: Initial Eligibility / New Hire Late Applicant Approved Annual Enrollment
 Change Nature of Change(s): _____

_____ / ____ / _____ F M
First Name **Middle Initial** **Last Name** **Date of Birth** **Age** **State of Birth** **Gender**

(Home Address) Street **Apt.** **City** **State** **Zip** **Daytime Phone Number**

Social Security Number **Date of Hire** **Job Title or Position** **Number of Hours Worked Per Week**

Are you actively performing all the duties of your occupation or profession? YES NO
 IF "NO", explain: _____

▼ COVERAGE SELECTION ▼

Select the insurance plans and benefit levels that meet your needs. Have your Plan Highlights sheets and Premium Table sheets handy for reference. Plans may have limitations, exclusions, reduction in benefit provisions and terms under which coverage may be continued in force or terminated. **Read your Certificate of Insurance carefully.**

PLAN	"YES" AUTHORIZES EMPLOYER TO PAYROLL DEDUCT PREMIUMS	(A)DD or (C)HANGE	TOTAL AMOUNT OF COVERAGE APPLIED FOR	IF (C), I WANT TO CHANGE EXISTING BY	PREMIUM
Voluntary AD&D: Employee	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____	+ \$ _____ - \$ _____	See Premium Table
Voluntary AD&D: Spouse (Coverage subject to election of employee AD&D)	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____	+ \$ _____ - \$ _____	See Premium Table
Voluntary AD&D: Dep Children (Coverage subject to election of employee AD&D)	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____	+ \$ _____ - \$ _____	See Premium Table
Voluntary Term Life: Employee (Evidence of Insurability (EOI) may be required - see accompanying EOI form.)	<input type="checkbox"/> YES <input type="checkbox"/> NO*		\$ _____	+ \$ _____ - \$ _____	See Premium Table
Voluntary Term Life: Spouse (Evidence of Insurability (EOI) may be required - see accompanying EOI form.)	<input type="checkbox"/> YES <input type="checkbox"/> NO*		\$ _____	+ \$ _____ - \$ _____	See Premium Table
Voluntary Term Life: Dep Children (Coverage subject to election of employee or spouse Term Life)	<input type="checkbox"/> YES <input type="checkbox"/> NO*		<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	TO: <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	See Premium Table

* If you check "NO", please note that if you desire insurance on yourself and/or your spouse (if applicable) at a later date: (1) you may be required to furnish, at your own expense, evidence of each person's insurability; and (2) Reliance Standard will have the right to refuse your request.

▼ **BENEFICIARY INFORMATION** ▼

◆ **Complete the following:**

Your Beneficiary's Name*			Relationship to You	Date of Birth Month/Day/Year	Social Security Number
First	Middle Initial	Last			
Primary					
Contingent					

* **IMPORTANT:** When naming a female beneficiary, show the name as Jane J. Doe, *not* Mrs. John H. Doe.

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. You are automatically the Beneficiary for Dependent Insurance, unless you otherwise specify. To designate more than one Primary or Contingent Beneficiary, attach a completed Reliance Standard Designation of Beneficiary form (obtain this form from your Benefits Administrator). Your intentions must be clearly set forth.

▼ **ADDITIONAL INFORMATION** ▼

◆ **IF YOU SELECTED TERM LIFE INSURANCE, complete the following:**

Spouse Information (Complete ONLY if you selected TERM LIFE INSURANCE for your spouse)

_____			<input type="checkbox"/> F <input type="checkbox"/> M
First Name	Middle Initial	Last	Gender
_____	_____	_____/_____/_____	_____
Social Security Number	Age	Date of Birth	State of Birth

▼ **READ, SIGN AND DATE BELOW** ▼

I understand and agree that: ● The information provided on this Enrollment Application is true and correct to the best of my knowledge. ● The insurance requested on this Enrollment Application will become effective in accordance with the individual effective date information in the Certificate of Insurance; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard. 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 Application 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 for enrolled dependents confined to a hospital or at home. ● Benefits are subject to terms and conditions of the Policy. ● For a plan with age-banded rates, 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 this Enrollment Application, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

Please Note: During an approved enrollment, guaranteed issue (GI) amounts of life insurance will not require evidence of insurability provided this form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to life 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 life 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 GI / EOI rules.

✍

 Employee's Signature Date

SUPPLEMENT TO ENROLLMENT APPLICATION EVIDENCE OF INSURABILITY for TERM LIFE INSURANCE

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 Policy Number: VG 648564
 BG 000001
 RSO Michigan
 VG GI: \$30,000/\$10,000/\$20,000/No

IF YOU SELECTED TERM LIFE INSURANCE, this Evidence of Insurability form must be completed...

- ◆ ...if you selected an Amount for yourself and/or your spouse (if applicable) that is above the Guaranteed Issue limit.
- ◆ ...if you and/or your spouse (if applicable) is a late applicant.
- ◆ ...if, during your present service with your employer or an affiliate, you and/or your spouse (if applicable) have, with respect to life insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated.
- ◆ ...if you are enrolling during an approved annual enrollment after your initial enrollment period or initial eligibility period and there are specific Guaranteed Issue/evidence of insurability rules.

If you have any questions about completing this form, see your Benefits Administrator.

INSTRUCTIONS:

All sections must be completed to ensure accurate processing. **PRINT IN BLUE OR BLACK INK.**

You must sign/date this form. Your spouse (if applicable) must also sign/date this form if you complete this form with respect to insurance you selected for him/her.

▼ EMPLOYEE INFORMATION ▼

_____/_____/_____
 First Name Middle Initial Last Name Date of Birth Social Security Number Date of Hire

▼ HEALTH QUESTIONS ▼

Current (h)eight and (w)eight: **Employee** (h)____ (w)____ **Spouse** (h)____ (w)____

Primary Care Physician: **Employee** _____
 (Full name, address, telephone)
Spouse _____

Have you or your spouse (if applicable) had, been told you had/have or been treated for any of the following within the past five (5) years:

1. Consultation with any physician or received any medical care, treatment or advice? YES NO
2. To the best of your knowledge, any physical impairment or disease? YES NO
3. AIDS, AIDS-related complex (ARC) or disorder of the immune system? YES NO
4. A disease of the nervous, genito-urinary or digestive systems, heart or lungs, high blood pressure, diabetes, cancer or a tumor of any kind? YES NO

If you answered "YES" to any of the above questions, give details in #5 below.

5. Question #	Person to Whom it Applies	Illness or Nature of Injury	Date	Physician's Full Name (and address if different from Primary)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(If you need more space, use a separate sheet of paper, **sign and date it, check here** _____ and **attach it** to this page.)

▼ READ, SIGN AND DATE BELOW ▼

I understand and agree that: ● The information provided on this Evidence of Insurability form is true and correct to the best of my knowledge. ● The insurance requested on the Enrollment Application will become effective in accordance with the individual effective date information in the Certificate of Insurance; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard. 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 Application 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 for enrolled dependents confined to a hospital or at home. ● Benefits are subject to terms and conditions of the Policy. ● For a plan with age-banded rates, 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 Application, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

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

AUTHORIZATION: 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 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 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 (or my authorized representative) will be sent a copy of this Authorization upon request.

Please Note: During an approved enrollment, guaranteed issue (GI) amounts of life insurance will not require evidence of insurability provided the Enrollment Application is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to life 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 life 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 GI / EOI rules.

x _____
Employee's Signature

Date

x _____
Spouse's Signature
(Your spouse must sign/date if you completed this form with respect to insurance you selected for him/her.)

Date

**Attach this form to your Enrollment Application.
Submit both forms at the same time.**

Keep the "Notice Regarding Information Practices" for your records.

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 you: (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 ("MIB").

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 (TTY 866-346-3642 for hearing impaired). 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 **DELPHI** company

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