reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Instructions: Use this form only for cases that offer the employee the ability to purchase voluntary disability coverage. Type or print with ballpoint pen. The employee and the policyholder must each receive a copy of the completed Group Disability Enrollment Form.

Group Disability Enrollment Form

All sections must be completed to ensure accurate processing.

(1) Policyholder/Employer			(2) RSL Policy No.
(3) Location/Bill Group	(4) Full-Time Employment Date / /		(5) Class
(6) Hours Per Week	(7) Job Title	(8) Base Salary $	☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly ☐ Bi-Weekly
(9) Employee's Full Name Last First MI			(10) Payroll Cycle I receive my paycheck: ☐ Weekly ☐ Monthly ☐ Bi-Weekly ☐ Other: _____ ☐ Semi-Monthly
(11) Social Security Number	(12) Gender ☐ Male ☐ Female		(13) Employee's Birth Date

Choose Only One (14) or (15)

(14) **Request for Group Insurance Coverage**

☐ I request to purchase Group Disability Insurance Coverage in the amount of _____ ☐ per week ☐ per month as described in the Policy. I authorize my employer to deduct from my salary or wages the necessary premium for the coverage requested above. The signature below also verifies the accuracy of the information contained on this form.

(15) **Declination of Group Insurance Coverage**

☐ I have been offered and have declined to purchase the Group Disability Insurance Coverage. I understand that in the event I desire such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) Reliance Standard Life Insurance Company (RSL) will have the right to refuse my request.

I understand that any coverage will not become effective until and unless approved by RSL, and upon approval, any benefits payable are subject to the terms, conditions and limitations of the Group Disability Policy. I also understand that the amount of any payroll deduction may be adjusted based on underwriting changes or age changes that affect the rates charged.

_____ **Employee Signature**

_____ / / **Date**

Please sign, date and return enrollment form to your Plan Administrator upon completion.

BOD