

## **Instructions for Providing Evidence of Insurability**

Attached is an Evidence of Insurability (EOI) form. This form has been provided to you to fill out and return to us because you enrolled in an amount of insurance that exceeded what could be approved without medical questions for you or for your spouse.

### **HOW TO COMPLETE THE FORM:**

Please fill out the following sections of the form **COMPLETELY**:

- Employee information section.
- Spouse information section (if applying for coverage on your spouse).
- Health questions for you if you are applying for coverage, for your spouse if they are applying for coverage and for both you and your spouse if both of you are applying for coverage.
- Make sure you have completed the height and weight section above the health questions and the primary care physician information below the health questions.
- Details section for any “Yes” answers to the health questions.
- Sign the form (make sure the spouse also signs if applying for coverage on your spouse).

### **WHERE TO RETURN THE FORM:**

Please return the completed EOI form by mail or via fax.

Forester Benefits Management, LLC  
1909 Pinnacle Point Way  
Knoxville TN 37922  
(865) 770-4422 Fax

We do not recommend returning the form to Reliance Standard as we cannot track the status of your request. Please return directly to Forester Benefits Management.

### **DEADLINE TO RETURN THE FORM:**

The form must be completed and returned **no later than 30 days after the plan effective date**. If it is not received by that date, then the request for coverage will be withdrawn.

### **QUESTIONS ABOUT THE FORM:**

If you have questions about how to fill out the form, you can ask the benefits counselor who provided you the form or contact Forester Benefits via email at [benefitshelp@foresterbenefits.com](mailto:benefitshelp@foresterbenefits.com) or by phone at 865-862-6048.

**Reliance Standard Life Insurance Company  
Enrollment and Statement of Health**

Name of Employer Geo Academies		Location/Division		Bill Group 000001
Policy # and Class # GL1500000600 / 01				

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, domestic partnership, divorce, dissolution of a partnership 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@rsl.com](mailto:EOIApplications@rsl.com) or

**Reliance Standard  
P.O. Box 7818  
Philadelphia, PA 19101-7818**

We do not accept faxed forms.

Name			Social Security Number/Employee ID		
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" includes domestic partner.)**

Spouse Name	Gender	Date of Birth	Age	State of Birth
Address	City	State	Zip	

**Coverage Elected and Amounts**

Coverage	Enroll or Decline <sup>1</sup>	Current Amount	Increase or Decrease	Total Amount Applied For	Semi-Monthly Premium
<b>Group Term Supplemental Life Employee<sup>2</sup></b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> Other\$ _____	See Premium Table
<b>Group Term Life: Spouse<sup>2,3</sup></b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> Other\$ _____	See Premium Table
<b>Group Term Life: Dep. Children<sup>3</sup></b>	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$10,000	See Premium Table

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
<b>Enter height and weight.</b>	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 (hepatitis or 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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); cystic fibrosis or emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 tested positive or been treated for HIV (Human Immunodeficiency Virus) antibodies, AIDS or AIDS-related complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 10 years, have you or your spouse been diagnosed or treated for Alzheimer's Disease, dementia, Parkinson's or motor neuron diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Answer question 7 only if applying for Critical Illness insurance.</b>		
7. Have two or more of your or your spouse's biological parents, brothers or sisters (either living or dead) been diagnosed with the same condition from the following list of conditions: diabetes, heart disease, stroke, kidney disease or cancer (other than skin cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee/Member Name	Date of Birth
----------------------	---------------

Employee/Member Primary Care Physician's Full Name	Office Phone Number
Address	
Spouse Primary Care Physician's Full Name	Office Phone Number
Address	

**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	Spouse

If you need more space, check here . Complete, sign and date a separate sheet of paper and attach it to this page.



## Important Information Regarding Applications for Insurance

The information provided on the Enrollment and Statement of Health form will be used in determining the insurability of a person proposed for insurance. Responsible parties completing and submitting a Statement of Health form are required to be made aware of the following statements concerning the consequences of insurance fraud. The lack of an applicable statement shall not constitute a defense against penalties.

**ALABAMA, ARKANSAS and LOUISIANA** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **COLORADO** — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **FLORIDA** — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **KENTUCKY** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **MAINE** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MARYLAND** — Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **MASSACHUSETTS** — Any person who knowingly presents a false or fraudulent claims for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NEW JERSEY** — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NEW MEXICO** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NEW YORK** (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 and the stated value of the claim for each such violation. **OHIO** — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **PENNSYLVANIA** — 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 subjects such person to criminal and civil penalties. **RHODE ISLAND** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **TENNESSEE, VIRGINIA, and WASHINGTON** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **WASHINGTON, DC** — WARNING: It is a crime to provide false or 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.

### KEEP THIS INFORMATION PAGE FOR YOUR RECORDS.

- ◆ If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured
------	----------------------



**reliancestandard**

LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

**Home Office: Schaumburg, Illinois  
Administrative Office: Philadelphia, Pennsylvania**

### **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 MIB, LLC.

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](http://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. 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.**



**reliancestandard**

LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

**Home Office: Schaumburg, Illinois  
Administrative Office: Philadelphia, Pennsylvania**