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 <u>no later than 30 days after the plan effective date</u>. If it is not received by that date, then the request for coverage will be withdrawn.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 or by phone at 865-862-6048.

Reliance Standard Life Insurance Company Enrollment and Statement of Health Name of Employer Location/Division Bill Group Geo Academies 000001 Policy # and Class # GL1500000600 / 01 ☐ Initial Eligibility/New Hire ☐ Late Applicant Application Type: □ 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 Social Security Number/Employee ID Name and Statement of Health form to: Gender Date of Birth State of Birth Date of Hire Age EOIApplications@rsli.com or Address City State Zip Reliance Standard P.O. Box 7818 Phone Number Occupation **Annual Compensation** Hours Worked Per Week Philadelphia, PA 19101-7818 **Email Address** We do not accept faxed forms. Are you actively performing all the duties of your occupation or profession? \square Yes \square No If "No," explain: Spouse Information – Complete Only If Applying for Spouse Coverage ("Spouse" includes domestic partner.) Spouse Name Date of Birth State of Birth Gender Age Address City State Zip Coverage Flected and Amounts

Coverage	Enroll or Decline ¹	Current Amount	Increase or Decrease	Total Amount Applied For	Semi-Monthly Premium
Group Term Supplemental Life Employee ²	☐ Enroll☐ Decline			☐ \$10,000 ☐ \$50,000 ☐ \$100,000 ☐ \$150,000 ☐ Other\$	See Premium Table
Group Term Life: Spouse ^{2,3}	□ Enroll □ Decline			□ \$5,000 □ \$10,000 □ \$15,000 □ \$20,000 □ \$25,000 □ Other\$	See Premium Table
Group Term Life: Dep. Children ³	□ Enroll □ Decline			□ \$10,000	See Premium Table

A MEMBER OF THE TOKIO MARINE GROUP

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
	Enter height and weight.	Htftin. Wt lbs	Htftin. 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?	□ Yes □ No	□ Yes □ 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?	☐ Yes ☐ No	☐ Yes ☐ 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)?	□ Yes □ No	☐ Yes ☐ 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)?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
Ans	swer question 7 only if applying for Critical Illness insurance.		
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)?	☐ Yes ☐ No	☐ Yes ☐ No

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Employee/Member Name			Date of Birth		
Employee/M	lember Primary Care Physician's Full Na	me	<u>.</u>	Office Phone	e Number
Address					
Spouse Prim	nary Care Physician's Full Name			Office Phone	e Number
Address					
Details					
lease provide	e all names used for medical records	(if different that	an the names provided on thi	s form):	
or each "Yes"	response to a health question, please pr	ovide details be	elow.		
Questio	Illness or Nature of Injury	Date	Physician's Full Name and	d Address	Check One

Questio n#	Illness or Nature of Injury	Date	Physician's Full Name and Address Check C (if different than Primary) Employee or	

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

Read, Sign and Date Below

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. 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 form 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 enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, 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 form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further 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 may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of the "Designation of Beneficiary" form and "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices". If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy will determine to whom benefits, if any, will be payable.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the MIB, LLC. 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 of my personal health information to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I 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 amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to 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 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 guaranteed issue/health acceptability rules.

rules.			
X Employee's/Member's Signature (required at all times)	Date	XSpouse's Signature (required if spouse Statement of Health required)	Date)

LRS-9457-0118

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 Heath 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
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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 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 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) 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.



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