

Instructions: Complete both pages. Type or print using ballpoint pen.
 The employee and the policyholder must each receive a copy of the completed Enrollment Card.

First Reliance Standard Life Insurance Company

Group Enrollment Card

Employer Section	(1) Policyholder _____		(2) Policy No. _____		
	(3) Location _____	(4) Full Time Employment Date _____		(5) Class _____	
	(6) Hours Per Week _____	(7) Occupation _____	(8) Salary \$ _____	<input type="checkbox"/> Hrly. <input type="checkbox"/> Mthly. <input type="checkbox"/> Wkly. <input type="checkbox"/> Yrly.	
Employee Section	(9) Employee's Last Name _____		First _____	Middle Initial _____	
	(10) Employee's Birth Date _____		(11) Social Security Number _____		(12) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	(13) Beneficiary(ies) Full Name(s) _____		Relationship _____	% of Proceeds _____	
See Reverse Side For Declination of Insurance	(14) I request to purchase the following Group Insurance Coverages: <input type="checkbox"/> Weekly Income <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Supp. Life				
	I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage(s) requested above. This signature is also to verify (1) the accuracy of the information contained on this card; and (2) the beneficiary (ies) I have designated.				
	FRAUD WARNING: (Not applicable to life insurance) 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.				
Employee Signature _____				Date _____	

Instructions: Complete both pages. Type or print using ballpoint pen.
The employee and the policyholder must each receive a copy of the completed Enrollment Card.

Declination of Group Insurance Coverage

(15) Employee's Last Name First Middle Initial

(16) This Coverage Can Be Declined Only IF You Pay Part Or All Premiums

I have been offered and declined to purchase the following Group Insurance Coverages:

' Weekly Income ' Long Term Disability ' Life/AD&D ' Supp. Life

I understand that in the event I desire such insurance at a later date: (1) I will be required to furnish evidence of insurability for myself at my own expense; and (2) the insurance company will have the right to refuse my request.

EMPLOYEE SECTION
COMPLETE IF DECLINING
GROUP INSURANCE COVERAGE

_____ Employee Signature

_____ Date