

**EMPLOYER:** We do not accept faxed applications.  
 Submit completed applications for insurance to:  
 Reliance Standard  
 PO BOX 7818 PHILA PA 19101

Buena Park School District

**PART. UNIT # VG** 177148  
**BILL GROUP** 1  
**RGO #** 770

**TERM LIFE  
 INSURANCE  
 APPLICATION**

**HOW TO APPLY:**

**COMPLETE IN INK.  
 PLEASE PRINT OR  
 TYPE ALL INFOR-  
 MATION, WITH THE  
 EXCEPTION OF  
 SIGNATURES.**

- For the Guaranteed Issue Amount, complete **Sections A and B**.
- If you desire coverage in excess of the Guaranteed Issue Amount, or you are a late enrollee, complete **Sections A, B and C**.
- If you desire coverage on your spouse only and/or your children, complete **all Sections** of the application.
- Please sign and date the back of this application.**
- Return the application to your personnel office for processing.

**A**  
 Applicant's Name (First-Middle-Last)  Male  
 Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_ Date Hired \_\_\_\_\_

Amount of Coverage Applied For \$ \_\_\_\_\_

- Initial Application (with RSL)  
 Change in Amount of Coverage (with RSL)  
 Total Amount with Change \$ \_\_\_\_\_

**Name of Beneficiary and Relationship**  
 \_\_\_\_\_  
 \_\_\_\_\_

**B** Are you actively performing all the duties of your occupation or profession?  YES  
 NO  
 IF NO, EXPLAIN.  
 \_\_\_\_\_  
 \_\_\_\_\_

Is this insurance now applied for intended to replace, in whole or in part, any insurance on the life of the applicant, spouse or dependent children?  YES  
 NO

IF YES, PROVIDE NAME OF COMPANY AND AMOUNT OF INSURANCE.  
 \_\_\_\_\_  
 \_\_\_\_\_

**Guaranteed Issue Amounts-**

Initial Enrollment or Newly Eligible:  
 Employee Under Age 60: \$50,000  
 Employee Age 60 but Under Age 70: \$20,000  
 Spouse Under Age 60: \$50,000  
 (provided employee applies for at least \$50,000)

**D** Spouse's Name (First-Middle-Last)  Male  
 Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Amount of Coverage Applied For \$ \_\_\_\_\_

- Initial Application (with RSL)  
 Change in Amount of Coverage (with RSL)  
 Total Amount with Change \$ \_\_\_\_\_

**Eligible Dep. Children Coverage:**  YES  NO

**If Dependent Children are to be covered, please select an amount below:**

- All children age 14 days to 6 months: \$1,000  
 All children age 6 months to 26 years:  
 \$2500  \$5000  \$7500  \$10,000

(Unless otherwise listed below, employee is automatically the Beneficiary for Dependent Life Insurance.)

**Name of Beneficiary and Relationship**  
 \_\_\_\_\_  
 \_\_\_\_\_

**C** Have... You or your spouse had; been told you had/have; or been treated for any of the following within the past five years:

- |  |  |
|--|--|
| <b>1</b> Consultation with any physician or received any medical care, treatment or advice? <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>2</b> To the best of your knowledge, any physical impairment or disease? <input type="checkbox"/> YES <input type="checkbox"/> NO   |
| <b>3</b> AIDS, AIDS related complex, or disorder of the immune system? <input type="checkbox"/> YES <input type="checkbox"/> NO                      | <b>4</b> A disease of the nervous, genito-urinary or digestive systems, heart or lungs, high blood pressure, diabetes, cancer or a tumor of any kind? <input type="checkbox"/> YES <input type="checkbox"/> NO |

**If you answered YES to any of the questions in Section C, give details in #5 below.**

<b>5</b> Question #	Person to Whom It Applies	Illness or Nature of Injury	Date	Doctor's Full Name and Address
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**PLEASE SEE REVERSE SIDE ►►►**

- **I REPRESENT** that to the best of my knowledge and belief each of the statements and answers is complete and true. I understand that 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 applications have been completed. I understand that only Reliance Standard has the authority to issue insurance coverage. If coverage is issued, Reliance Standard will provide a Certificate of Insurance (or, in some states, an individual Policy) for the employee showing the personal effective date of insurance. No insurance is in effect prior to the personal effective date and such effective date is applicable only if on that date the employee: is eligible for the coverage; has satisfied any service waiting period required by the employer; and the first premium for the coverage is paid when due. Additionally, the effective date may be deferred in accordance with coverage provisions regarding an employee who is not actively at work on the date coverage would otherwise go into effect and any enrolled dependent who is confined in a hospital or at home on the date coverage would otherwise go into effect.
- **I CERTIFY** that I am an employee of the sponsoring organization or otherwise meet the eligibility requirements for applying for this insurance.
- **I AUTHORIZE** my employer to deduct the applicable premium from my salary as consideration for Term Life Insurance on me and/or my family issued by Reliance Standard. If deduction of premium(s) should occur prior to Reliance Standard processing this application, I understand that it does not mean that coverage is in effect (premium(s) paid for coverage not issued will be returned). I authorize Reliance Standard to adjust these deductions based on underwriting changes, or rate changes resulting from age changes. During the continuance of this agreement, my employer will forward the premium to Reliance Standard as it falls due. This authorization may be revoked by me by written notice to my employer.
- **I ACKNOWLEDGE** receipt of the "Notice Regarding Information Practices".
- **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 records(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 am entitled to receive a copy of this Authorization upon request.
- **PLEASE NOTE:** During an approved enrollment, guaranteed issue amounts of insurance will not require medical evidence provided this application is complete, signed and received by your employer during the enrollment period and the applicant was not previously declined for insurance coverage by Reliance Standard, postponed, had an application withdrawn or voluntarily terminated insurance with Reliance Standard.

**Please review the front of the application for completeness before signing. Incomplete sections may cause coverage to be delayed or declined.**

Signature	X _____	_____
	Applicant	Date
	X _____	_____
	Spouse (only if coverage on spouse is requested)	Date

**REQUEST TO WAIVE COVERAGES OFFERED**

I certify that I have been advised of the features and benefits of the program offered to me through my employer and have decided not to participate.

X _____	_____
EMPLOYEE SIGNATURE	Date

## 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 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

**KEEP THIS NOTICE FOR YOUR RECORDS.**

**RELIANCE STANDARD**

Life Insurance Company

a DELPHI company

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