**First Reliance Standard Life Insurance Company** **Group Enrollment Card**

Philadelphia Administrative Office: 2001 Market Street Suite 1500, Philadelphia, PA 19103

**Employer Section**

(1) Policyholder

(2) Policy No.

(3) Location

(4) Full Time Employment Date

(5) Class

(6) Hours Per Week

(7) Occupation

(8) Salary Hrly. Mthly.
**$** Wkly. Yrly.

**Employee Section**

(9) Employee's Last Name First Middle Initial

(10) Employee's Birth Date
month date year

(11) Social Security Number

(12) Sex
Male Female

(13) Beneficiary(ies) Full Name(s) Relationship Date of Birth Social Security Number % of Proceeds

(14) I request to purchase the following Group Insurance Coverages:
Weekly Income Long Term Disability Life/AD&D Supp. Life Dependent Life

**See Reverse Side For Declination of Insurance**

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

FRSL-8564-0405

EMPLOYEE SECTION
COMPLETE IF DECLINING
GROUP INSURANCE COVERAGE

**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 Dependent 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 Signature Date