RELIANCE STANDARD
LIFE INSURANCE COMPANY

New Business Checklist

Please confirm that the following is submitted with all new cases.

- ❑ Completed employer application for group insurance
- ❑ Completed employee enrollment census spreadsheet
- ❑ Sold Quote with elected plan and rates from www.directbenefits.com
- ❑ If electing ACH, please complete included form and include a voided check with enrollment paperwork
- ❑ Please note that a completed beneficiary form must be kept on file by the group's administrator but is not required in enrollment submission

Policy Documents Delivery Acknowledegment

Policy documents will be delivered how requested on the master application. Hard copy ID cards are not mailed, they are accessible through the portal after implementation.

After all the information listed above is completed and signed, submit all forms using one of the following delivery methods:

Email: agentsupport@directbenefits.com

Fax: **651-649-3502 ATTN: Group Sales**

Mail: **Direct Benefits, Inc.**
55 East 5th Street, Suite 500
Saint Paul, MN 55101

Submission Date:
New groups should be received by Direct Benefits no later than the 3rd of the month of the desired effective date in order to submit to the carrier (*i.e. Feb 1st effective date, please submit to Direct Benefits by Feb 3rd)*.

DirectBenefits
AN ALERA GROUP COMPANY

RELIANCE STANDARD
LIFE INSURANCE COMPANY

SmartChoice Binder and Recurring Payment Authorization Form

THIS PORTION IS TO BE COMPLETED BY RELIANCE STANDARD LIFE INSURANCE COMPANY
SECTION 1:

Office Number:_____ Customer Number: _____Customer Name:_____

Sales Representative: _____Payment Amount: _____

CUSTOMER COMPLETES FOLLOWING SECTIONS

SECTION 2: BINDER PAYMENT

- Binder Payment - ACH Debit: Authorize Reliance Standard to make a one-time debit to your designated bank account
    - You may choose to enroll in Paper or Online Billing

☐ ACH Debit Binder Payment*

SECTION 3: RECURRING PAYMENT

- Recurring Payment – ACH Debit: Authorize Reliance Standard to make recurring monthly debits to your designated bank account
    - You must be enrolled in Online Billing to utilize this feature

☐ ACH Debit Recurring Payment**

SECTION 4: BANK INFORMATION

1. Bank Name: _____
2. Bank City/State: _____
3. ABA Routing Number: _____
4. Bank Account Number: _____
5. Account Name: _____
6. Amount: _____

**If ACH Debit Binder Payment is checked, your signature below authorizes Reliance Standard Life Insurance Company (RSL) to debit your account for the above indicated amount. If your bank requires third party pre-authorization, please provide them with our Company ID # as follows: 8636088376.*
*** If ACH Debit Recurring Payment is checked your signature below authorizes Reliance Standard Life Insurance Company (RSL) to initiate monthly withdrawals (debit entries) from your bank account using the information provided above. Monthly payments will be electronically debited from your business checking or savings account in the amount of my monthly premium due. This authorization is to remain in full force and effect until Reliance Standard Life Insurance Company has received notice from you of its termination in such time and in such manner as to afford Reliance Standard Life Insurance Company a reasonable opportunity to act on it. If there are insufficient funds during any given month, You understand that RSL may charge a non-sufficient funds (NSF) fee. You authorize the debit of this fee in full and acknowledge that Reliance Standard Life Insurance Company will not be responsible for any fees imposed by my financial institution.*

SIGNATURE _____ DATE _____
**By typing your name above, you are signing this form electronically and agree to the legal equivalent of a manual signature.*

UPON COMPLETION, PLEASE ENSURE THIS FORM IS RETURNED TO RELIANCE STANDARD LIFE INSURANCE COMPANY

First Reliance Standard Life Insurance Company

Employer Information

Please fill in where appropriate. Incomplete applications will delay processing.

Employer's Legal Name _____ Employer's Tax ID# _____

Employer's Business Address _____

City _____ State _____ ZIP Code _____

Firm Contact _____ Title _____ Telephone (_____) _____

Fax (_____)_____ E-mail address_____ Effective Date Requested___ /___ /___

Years in Business _____ SIC Code & Nature of Business _____

Preferred method of billing: ☐ **Electronic*** ☐ **Paper** *** For firms applying for Dental/Vision, Electronic billing not available.**

Type of Business Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other _____

Should K1 Earnings be included in Definition of Earnings shown below? ☐ Yes ☐ No

Are any subsidiary or affiliated companies to be insured? ☐ Yes ☐ No

(If yes, please provide name(s), address(es), and nature of business with this application)

Is there any other Group or employer sponsored Individual Life/AD&D, Dental, Eye Care, STD, or LTD coverage in force or currently being applied for on some or all employees? ☐ Yes ☐ No

If yes, please specify type(s) and effective date(s) of coverage:

_____

_____

Definition of Earnings (for Life/AD&D, Short and /or Long Term Disability): Basic salary exclusive of overtime, bonuses and other special forms of compensation. Commission earnings will be based on the average earnings of the previous 24 months. (K1 Earnings included if applicable)

Definition of Employee Eligibility: Eligible employees are those actively working full time for a minimum of 30 hours per week year round (non-seasonal) who have satisfied the employer's minimum service requirement. Eligibility may be modified to include part-time employees working a minimum of 20 hours per week, provided less than 25% of the eligible employees are working less than 30 hours per week.

Employer's Minimum Service Requirements

A. All employees actively at work on or before the coverage effective date are eligible following the completion of:
☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days of active service

B. All new employees (actively at work after the coverage effective date) shall become eligible on the first day of the month following the completion of:
☐ 30 days ☐ 60 days ☐ 90 days of active service

Definition of Dependent Eligibility (For Dental): Eligible dependents include the insured employee's spouse and unmarried children prior to their 19th birthday who do not work for the firm. In addition, unmarried children from their 19th birthday to the day before their 24th birthday are eligible if they are full time students attending an accredited educational institution and primarily dependent upon the employee for support and maintenance. NOTE: Dependent ages may vary by state.

Participation Requirements:
For groups of 2 eligible employees – both eligible employees must be insured
For groups of 3 to 5 eligible employees – all eligible employees but one must be insured
For groups of 6 to 9 eligible employees – all eligible employees but two must be insured
For groups of 10 to 19 eligible employees – 75% of all eligible employees must be insured
(If employees do not contribute toward cost of insurance, there must be 100% eligible employee participation)

- If classes of employees are insured, these participation minimums must be maintained within each class.
- For Dental coverage, these participation requirements apply to eligible dependents as well.
- For Dental coverage, employees and dependents that are covered for group dental elsewhere may be counted toward satisfying participation requirements with submission of signed waiver forms.

First Reliance Standard Life Insurance Company

Life/Accidental Death & Dismemberment (AD&D) (2 to 19 Lives)

Benefit Schedules: Option I Coverage based on ☐ 1x annual earnings ☐ 2x annual earnings Maximum Benefit _____

Option II Flat Amount Coverage of _____ for each employee ($10,000 minimum)

Number of Employees	Non-Medical Maximum Limit*	Maximum with Evidence	*Amounts elected in excess of the non-medical maximum limits will require medical underwriting
Insure 2-5	$ 50,000	$200,000	
Insure 6-19	$100,000	$200,000	

Employer will pay _____ % of employee premium (employees may contribute up to 100% of premium provided all participation requirements are met)

Employer will insure ☐ all employees
☐ one or more classes of employees (describe below)
_____
_____

Participation: Total number of eligible employees _____
Total number of employees applying _____

Dental (2 to 19 Lives) Choose Plan

Plan Selected (Annual Plan Maximum)
- Add the MAC Option:
- Add the Eye Care Option:
- Increase to a 24 Month Initial Rate Guarantee
- Increase to a $2500 Annual Plan Max
- Move Endodontic Coverage to Basic Services
- Move Periodontic Coverage to Basic Services
- Non-Mac Plans – Increase Out Of Network Allowance to 90TH Percentile

Takeover (Plan A Only) – Is this plan replacing another Group Plan? ☐ Yes ☐ No If, yes, provide the following:

A. Name of carrier/policy number _____

B. Effective date of prior plan _____ C. Termination date _____

D. Attach a copy of the prior carrier's last bill

Elimination Period:

1. For Plans A there is a 12 month Major services elimination period for all current insureds which can be waived, along with "credit" given for calendar year deductibles accumulated under the prior plan, when Reliance Standard replaces a comparable dental plan that has been in effect continuously for at least 12 months prior to the effective date of Plan A or C.

2. Current insureds are all employees and dependents insured on the FRSL effective date. New hires to the group after the effective date must fulfill the usual elimination periods and deductibles.

Employer will pay _____ % of employee premium
_____ % of dependent premium
(employees may contribute up to 100% of premium
provided all participation requirements are met)

Employer will insure ☐ all employees
☐ one or more classes of employees (describe below)
_____
_____

Participation:

Total number of eligible employees _____ Total number of employees enrolling _____
Total number of employees waiving (due to coverage elsewhere) _____

Short Term Disability (2 to 19 Lives)

Benefit Schedules:

Option I Percentage of Earnings Plan ☐ 50% ☐ 60% ☐ 66.7% ☐ 70% (up to maximum benefit)

Option II Flat Benefit Per Week of _____ (not to exceed 70% of weekly earnings up to maximum benefit)

Maximum Benefit: $1,500 per week

Plan Duration: ☐ 13 weeks ☐ 26 weeks

Is this plan replacing another Group Plan?

☐ Yes (if yes, attach a copy of prior carrier's last bill and copy of contract or certificate of insurance)
☐ No

Employer will pay _____ % of employee premium (employee may contribute up to 100% of premium provided all participation requirements are met)

Employer will insure ☐ all employees ☐ one or more classes of employees (describe below)

_____

_____

Participation: Total number of eligible employees _____

Total number of employees applying _____

Long Term Disability (2 to 19 Lives)

Benefit: 60% of Earnings up to a maximum of $7,500 per month ($10,000 per month for select industries).

Benefit Duration: Up to Normal Retirement Age* for accident / illness

*Normal Retirement Age, as defined by the 1983 Amendments to the United States Social Security Acts as determined by year of birth.

Elimination Period: ☐ 60 days ☐ 90 days ☐ 180 days

Is this plan replacing another Group Plan?

☐ Yes (if yes, attach a copy of prior carrier's last bill and copy of contract or certificate of insurance)
☐ No

Employer will pay _____ % of employee premium (employee may contribute up to 100% of premium provided all participation requirements are met)

Employer will insure ☐ all employees ☐ one or more classes of employees (describe below)

_____

_____

Participation: Total number of eligible employees _____

Total number of employees applying _____

First Reliance Standard Life Insurance Company

Application Signatures

I (We) verify that all employees applying for coverage are actively at work and meet the eligibility requirements specified in the plan descriptions; that all employees applying for coverage do not work where they reside; and that all employees, including myself, who are applying for disability coverage do not have other disability insurance currently in force or applied for, that when added to this insurance would exceed 100% of his/her individual current monthly earnings.

I (We) verify that FRSL benefit plan(s) have been offered to all eligible employees. Completed waivers are attached for those employees and their dependents electing not to participate in the plan(s).

The undersigned employer requests that insurance be provided in accordance with employer's specifications for Group Insurance to which this request is attached and shall be subject to the terms of the Group Insurance Policies issued to the group by FRSL. The undersigned employer agrees that it will remit to the insurer regularly in advance, the required premiums as they become due.

We have read this form and understand that:

1. This request for coverage is not effective until approved by FRSL in writing. FRSL reserves the right to decline any case so coverage may be declined or the effective date may be deferred for incomplete submission of information as outlined in FRSL underwriting rules/standards. **Existing coverage should not be terminated until written approval has been received.**

2. All information given in connection with this request for participation is true and complete.

3. FRSL reserves the right to re-rate any coverage retroactively to the effective date or take other appropriate actions if any information provided to us is not true or is incomplete. Please note that changes to the census data, from what was originally submitted, may affect rates. Final premium rates are subject to final enrollment.

4. No provider can make or modify a contract for FRSL and all coverage will be as stated in FRSL policies.

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.

Premium Summary

Billing Mode (select one)	☐ Monthly Billing	☐ Quarterly Billing (3X monthly premium)
Dental	$ _____	$ _____
with Vision	$ _____	$ _____
Short Term Disability	$ _____	$ _____
Life/AD&D	$ _____	$ _____
Long Term Disability	$ _____	$ _____
Administration Fee*	$ _____	$ _____
* $12.00 Paper Billing		
Total SmartChoice Bill Amount	$ _____ Monthly	$ _____ Quarterly

I represent that all information on this application is correct to the best of my knowledge.

X _____ _____

Employer's Signature Date

First Reliance Standard Life Insurance Company
Census Information

	Employee's Social Security Number	Name (Last Name First)	Date of Birth M / D / Y	Sex M / F	Date of Hire M / D / Y	Occupation	Current Monthly Salary	Hours Worked Per Week	Coverage Selected			
									LTD	STD	Dental Status*	Life/ AD&D
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
11.												
12.												
13.												
14.												
15.												
16.												
17.												
18.												
19.												

***For Coverage Selected Dental** — Use status indicators of “S” for single, “+1” for employee plus one dependent or “F” for family coverage.

First Reliance Standard Life Insurance Company

Notification of Waiver Form (This form may be photocopied)

Please read, complete and sign this form if you are contributing toward the cost of coverage and are waiving coverage for any of the following insurance products: Life, Dental, STD and/or LTD.

Note: Under contributory plans (where employees contribute towards the cost of coverage), eligible employees may elect to waive coverage. However, election to waive may not exclude that employee from the employer's participation requirements. Under non-contributory plans, all eligible employees must enroll. Eligible employees are defined on Page 1 of the Request for Participation and Enrollment form.

Employee's Name: _____

Name of Employer: _____ Policy Number(s): _____

Employee Date of Birth: _____ Social Security Number: _____

Please check the box for type(s) of insurance coverage you are waiving:

☐ Life ☐ Dental ☐ STD ☐ LTD

If you are waiving dental coverage for yourself or your dependents, check all boxes that apply and provide information as applicable:

☐ I have similar dental coverage under my spouse's plan

☐ My dependents have similar dental coverage under my spouse's plan

If either or both above boxes are checked, please provide the following information:

Name of spouse's insurance company: _____

Spouse's plan effective date: _____

☐ I do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage

☐ My dependents do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage

Please read and sign:

I, the undersigned, hereby affirm that I have reviewed the insurance plan(s) from First Reliance Standard Life Insurance Company being offered by my employer. With my signature, I certify that I have decided to waive coverage as indicated above.

I understand that in the event I request to purchase such insurance at a later date: 1) I will be required to furnish evidence of insurability for myself (and any dependents, if such coverage is available) at my own expense; and 2) First Reliance Standard Life Insurance Company will have the right to refuse my request. For dental coverage, I may be subject to reduced benefits.

Signature _____ Date _____

First Reliance Standard Life Insurance Company

Producer's Statement

Name of Employer to be Insured _____

Attention Producer: This enrollment form must be completed in full. Missing information will delay the new business process. Make sure that all applicable submission requirements outlined on the cover page of the request for participation and enrollment form are completed.

Producer Instruction: If you are currently appointed with First Reliance Standard Life, you need only to complete the license number, First Reliance Standard Life producer number, and signature.

Producer Information (please type or print legibly):

Name _____ License number _____ State _____
Last Name First Name MI

Agency Name (if applicable) _____

Are you appointed with FRSL? ☐Yes ☐ No (if yes, FRSL producer number _____)

Address _____

City _____ State _____ ZIP Code _____

Social Security Number or Tax ID Number _____

Telephone (_____)_____E-mail _____ Fax (_____) _____

Pay Commissions to _____

Producer's Signature _____ Date _____

General Agent (if applicable)

Name _____

Reliance Standard
General Agent Number _____

Master General Agent

Name _____

Reliance Standard
Master General Agent Number _____