RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Voluntary Hospital Indemnity Plan

Employee Enrollment Form

You must complete Sections A and B. Complete Section C only if you are enrolling dependents. Make a copy of your completed Enrollment Form for your records. Please print neatly and firmly within the boxes.

SECTION A — INFORMATION ABOUT YOUR EMPLOYER

Employer Name:	Effective Date:
Bill Group Number:	Location/Division:

Application Type:

☐ Initial Eligibility / New Hire ☐ Other (Describe):

Nature of Change (If marriage, divorce or birth of a child, please provide documentation):

☐ Change in Status: Date of Change:

SECTION B — INFORMATION ABOUT YOU

Social Security Number:	First Name:	Middle Initial	Last Name:

Date of Birth:	Date of Hire:	Gender: ☐ Male ☐ Female

Mailing Address:	City:	State:	Zip Code:

Phone Number:	Email Address:

SECTION C — ENROLLMENT SELECTION

It is important that you follow the directions when making your election; otherwise, your enrollment may be delayed. And if you are enrolling any of your dependents (spouse or children), please be sure to include their information in Section D; otherwise, their enrollment may be delayed. Costs listed below are monthly amounts.

Make your selection by putting an in ☒the box next to the selection you want. List your Dependents on the back of this form.

Voluntary Hospital Indemnity Plan	
Employee Only	☐ $24.46
Employee + Spouse	☐ $51.61
Employee + Child(ren)	☐ $36.69
Employee + Family	☐ $ 63.84
DECLINE COVERAGE	☐

I wish to participate in the benefit plan that I've selected above and I authorize my employer to deduct the required costs from my paycheck.

APPLIES TO CALIFORNIA RESIDENTS—I certify that I (and any dependents that I enroll) have coverage for comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan and I am eligible to enroll for this hospital confinement indemnity insurance plan.

Your Signature:	Date:

(OVER PLEASE)

SECTION D — WHICH DEPENDENTS WILL BE COVERED?

1.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
2.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
3.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
4.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
5.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.
6.	First Name:	Middle Initial:	Last Name:
	Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
	Relationship: ☐ Your Spouse ☐ Your Child	If over 25, is your child **disabled**? ☐ Yes ☐ No	Check the box here ☐ if living at a different address and list below.

Dependent Not Living with You:	First Name:	Middle Initial:	Last Name:	
Mailing Address:	City:		State:	Zip Code:

If you have additional dependents or addresses for those dependents not living with you, please record all requested information on a separate sheet and attach it to this form.