

tobacco user. For your eligible dependent children, the monthly cost (regardless of the number of children) is determined by the age 6 months to age 20/26 benefit option you select, as follows:

Dependent Children (6 months to age 20/26) Benefit	Monthly Cost
\$ 2,500	\$.79
5,000	1.19
7,500	1.59
10,000	1.99

All dependent children coverage includes a \$1,000 benefit for each eligible child from 14 days up to 6 months of age. A newborn automatically becomes insured at 14 days of age; if you do not already have dependent children coverage at the time of your child's birth, then you must apply for dependent children coverage within 30 days of the birth for that child to continue to be insured beyond 30 days of age.

**MONTHLY PREMIUM RATES
PER \$10,000 OF LIFE INSURANCE**

Age (last birthday as of the anniversary date)	Tobacco User Rate	Non-Tobacco User Rate
Under age 30	\$ 1.42	\$.85
30-34	2.05	1.03
35-39	3.11	1.49
40-44	4.58	2.13
45-49	8.56	3.96
50-54	13.50	6.40
55-59	18.66	9.92
60-64	29.92	18.13
65-69	39.48	26.68
70 and Over*	59.29	43.28

*Note: For insureds age 75 and older, the above rates are equivalent to per \$10,000 of coverage in effect prior to age 75.

EXAMPLE:	Amount of Insurance	Monthly Cost
Employee - 33 (Tobacco User)	\$50,000	\$10.25
Spouse - 28 (Non-Tobacco User)	30,000	2.55
Three Children 6 months to age 20/26	2,500	.79
Total Monthly Cost		\$13.59

Monthly premium rates are based on your age at your last birthday and tobacco use status. They will change on the anniversary date coinciding with or next following your last birthday as you advance to a higher age bracket.

PORTABILITY: If you terminate employment after your coverage has started, you may elect within 31 days of

termination of eligibility, to continue your group term life insurance. Premiums will be billed directly to you on a quarterly, semi-annual or annual basis as you choose and will be based on the prevailing rate charged to all insureds who choose to continue coverage under the Portability provision. Insurance for your spouse terminates at age 75.

CONVERSION: If premiums are not waived due to total disability, you may convert your insurance to an individual permanent life insurance policy with RSL within 31 days of termination of coverage. You may also convert if you are no longer a member of an eligible class, or if your employer no longer participates in the group insurance trust. Under these circumstances, your spouse under age 70 and your insured dependent children may also convert. For each insured child who attains the maximum age for eligibility, up to five times their current amount of life insurance coverage may be converted.

TERMINATION: RSL may not terminate insurance coverage unless: premium is not paid when due; or insurance coverage is converted to an individual plan of insurance; or the maximum age is attained; or the Master Policy terminates. In addition to the above, insurance coverage on dependents may also be terminated when the dependent is no longer eligible.

BENEFICIARY DESIGNATION: You can designate your own beneficiary and you may change the designation (except an irrevocable designation) as your circumstances change. You will be the beneficiary for dependent coverage unless another person is designated.

This brochure describes the highlights of Group Term Life Master Policy Form Number LRS 8349-01-1188, but is not a contract. If a conflict exists between a statement in this brochure and any provision in the Policy, the Policy will govern. The Master Policy has been issued to a Rhode Island Trust and is subject to Rhode Island law.

Plan Arranged By:

CAPITAL INSURANCE AGENCY, INC.
1 PO BOX 15949
Tallahassee, FL 32301
For More Information, please call
1-800-942-1226
www.HallmarkInsuranceServices.com

Underwritten By:

RELIANCE STANDARD
Life Insurance Company

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

Voluntary Group Term Life Insurance Program

For Employees and Families of

State of Florida, Department of Revenue

- **Affordable Cost - High Limit Coverage**
- **Dependent Coverage Available**
- **Guaranteed Acceptance Amounts for Employee, Spouse and Dependent Children**
- **Conversion and Portability Provisions**
- **Living Benefit**

VOLUNTARY GROUP TERM LIFE INSURANCE: This plan offers you and your dependents an excellent opportunity to purchase affordable group term life insurance on a payroll deduction basis. The important plan features including high limits, guaranteed acceptance, conversion, portability rights and the Living Benefit Rider are summarized in this brochure. Please review it carefully and make your selection.

ELIGIBILITY: All active, Full-time Employees who are working a minimum of 30 hours per week are eligible to participate. Employees are not eligible and cannot enroll until their date of hire. Insurance is also available for an eligible employee's spouse, under age 70. Unmarried eligible dependent children from 14 days to age 20 (26 if a full-time student) may be insured if the employee or spouse is insured. Spouse insurance terminates at age 75; dependent children's at age 20 (26 if a full-time student).

BENEFITS: You and your spouse may select an amount of insurance from a minimum of \$10,000, in increments of \$10,000. The maximum amount available to employees up to age 75, and to their spouses under age 70, is \$500,000. The maximum amount available to employees age 75 and older is the percentage of \$500,000 shown below. Eligible dependent children from age 6 months to 20/26 years may be covered for your choice of \$2,500, \$5,000, \$7,500 or \$10,000 per child (dependent children insurance includes a standard \$1,000 benefit for children from 14 days of age up to 6 months).

Reduction: If this insurance is purchased prior to age 75, the amount of insurance will be reduced in accordance with the table below on the anniversary coinciding with or next following your last birthday.

At Age	Reduction To % Of Your Pre-Age 75 Amount Of Insurance
75	60%
80	35%
85	27.5%
90	20%
95	7.5%
100	5%

Neither you nor your spouse may hold more than a total of \$500,000 of group term life insurance with Reliance Standard Life Insurance Company (hereinafter "RSL") under the Master Policy. Insurance over that amount will be void and the premiums refunded.

GUARANTEED ISSUE: During an approved enrollment period, you must be an eligible employee who is actively performing all the regular duties of your occupation to enroll. You must complete, sign and return the application to your employer during the enrollment period. As long as you have not: been previously declined for insurance coverage by RSL; had your coverage postponed; had your application withdrawn; or voluntarily terminated your insurance with RSL, medical evidence will not be

required:

- if you are newly eligible and apply (within 31 days* of becoming eligible) for an amount of insurance up to \$100,000 if you are under age 60 when you apply, or \$10,000 if you are between age 60 and 70 when you apply.
- if you have been insured for six (6) months and are now applying for additional coverage of \$10,000 as long as your new total amount of insurance is no greater than \$150,000 if you are under age 60 when you apply, or \$20,000 if you are between age 60 and 70 when you apply.
- if you were previously eligible and are now applying for initial coverage of \$10,000.
- if you report a life event change that occurred since the last enrollment (such as marriage, birth or specific changes of employment status) and apply, within 31 days of the life event, for an amount of insurance up to \$100,000 if you are under age 60 when you apply, or \$10,000 if you are between age 60 and 70 when you apply.

Your spouse under age 60 is eligible for \$10,000 of guaranteed issue coverage provided you apply for at least \$50,000 of coverage. Your spouse must apply within 31 days* of becoming eligible, and if employed, must be actively performing all the regular duties of his/her occupation; if not employed, must be engaged in normal activities for a person of like age and sex. No medical evidence is required on dependent children.

* if you are an employee hired prior to 6/1/03; and 60 days if you are an employee hired on or after 6/1/03

EFFECTIVE DATE: Coverage for amounts up to the guaranteed issue limit will begin on the first day of the second month** following the date the application is signed, provided applicable premium is paid.

Applications for insurance amounts over the guaranteed issue limits (for employees under age and spouses under age 60/70), any amounts for employees age 70 and over and applications made beyond the first 31 days* of becoming eligible are subject to medical evidence submitted to and approved by RSL. Insurance will become effective on the first day of the second month** following the date the application is signed, provided RSL agrees to insure each applicant and applicable premium is paid. Dependent children coverage will begin on the first day of the second month** following the date the application is signed, provided you or your spouse are insured for this coverage and your dependent children are not confined in a hospital or at home. **Non-guaranteed issue amounts are not effective until approved by RSL. Payroll deduction of premiums for non-guaranteed issue coverage prior to such approval does not mean coverage is effective.** If coverage is not approved, any premium that has been collected will be returned.

After your insurance becomes effective, you will receive a certificate of insurance and a schedule page which you should read carefully. If there are discrepancies between the certificate and what you believe you applied for or you do not receive the certificate at all, contact your employer or RSL immediately.

*if you are an employee hired prior to 6/1/03; and 60 days if you are an employee hired on or after 6/1/03

**if you are an employee hired prior to 6/1/03; and the first of the month, if you are an employee hired on or after 6/1/03

LIVING BENEFIT: This benefit is designed to offset the high cost of medical care if you, your insured spouse or insured dependent children should become terminally ill. It provides an advance payment of 50% of the death benefit to a maximum of \$250,000. Coverage must be in force for 60 days prior to being diagnosed as terminally ill. An insured will be considered as terminally ill if he/she suffers from a physical condition which is certified by a physician to be expected to result in death within 12 months. In the event of death, the death benefit payable to the beneficiary will be reduced by the amount of any living benefit payment that was made. This benefit is payable one time only for any insured covered under this benefit. In no event will the amount of the living benefit plus the death benefit payable exceed the amount that would be payable if no living benefit was available.

DISABILITY WAIVER OF PREMIUM: All premiums due during your disability will be waived for you and your dependents if you become totally disabled prior to age 60 and disability lasts for six consecutive months. Premiums will be refunded back to the date disability began. Your coverage will remain in force without any premium payments as long as your disability continues, you are under age 70 and you are not retired. This benefit is not available for disabilities resulting from intentionally self-inflicted injury or war (declared or undeclared).

EXCLUSIONS AND LIMITATIONS: Death by suicide is not covered during the first two years insurance is in force. Insurance coverage is incontestable after it has been in force two years during the insured's lifetime, except for non-payment of premium.

PREMIUM: The monthly premium for the amount of group term life insurance coverage you select for yourself, your spouse, and dependent children is payable through the convenience of payroll deduction. The following chart shows the monthly premium cost per \$10,000 unit of life insurance coverage by age bracket and tobacco use status. To determine your premium, take your tobacco use status and age at your last birthday, find the rate in the following chart per \$10,000 unit of life insurance, and multiply that rate by the number of \$10,000 units you desire. If you have used any form of tobacco in the last 12 months, you will be considered a

NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, Reliance Standard Life Insurance Company (herein referred to as "we", "us", or "our") collects certain information about all proposed insureds (herein referred to as "you" or "yours"). 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, 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

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

**Reliance Standard Life Insurance Company
Enrollment and Statement of Health**

Name of Employer State of Florida, Department of Revenue		Location/Division 01		Bill Group 000001
Policy # and Class # VGTLO04057 / 01	Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #

Application Type: Initial Eligibility/New Hire Late Applicant Other _____
 Increase Approved Annual Enrollment
 Change in Status: Nature of Change(s): _____

Date of Change: _____

If marriage, domestic partnership, divorce, dissolution of a partnership, or birth of a child, please provide copy of document.

Employee/Member Information – Always Complete

Submit completed Enrollment and Statement of Health form to:

Name			Social Security Number		
Gender	Date of Birth	Age	State of Birth	Date of Hire	
Address			City	State	Zip
Phone Number	Occupation	Annual Compensation		Hours Worked Per Week	
Email Address					

Gene Hallmark Insurance, Inc.
"Employee Benefits Since 1972"
 genehallmarkinsurance@gmail.com

Phone 850-727-7101
 Fax 850-727-4905

Are you actively performing all the duties of your occupation or profession? Yes No

If "No," explain: _____

Have you used tobacco in any form in the last 12 months? Yes No

**Spouse Information – Complete Only If Applying for Spouse Coverage
("Spouse" includes a domestic partner.)**

Spouse Name	Gender	Date of Birth	Age	State of Birth
Address	City	State	Zip	

Has your spouse used tobacco in any form in the last 12 months? Yes No

**Child Information – Complete Only If Applying for Child Coverage
("Child" includes all children of a domestic partnership.)**

Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No	Child Name	Date of Birth	Handicapped <input type="checkbox"/> Yes <input type="checkbox"/> No

If you need more space, check here . Complete, sign and date a separate sheet of paper and attach it to this page.

Coverage Elected and Amounts

Coverage	Enroll or Decline ¹	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Voluntary Term Life: Employee ²	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other _____	See Premium Table
Voluntary Term Life: Spouse ²	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$10,000 <input type="checkbox"/> Other _____	See Premium Table

RELiance STANDARD
 LIFE INSURANCE COMPANY

Employee/Member Name	Date of Birth
----------------------	---------------

Coverage Elected and Amounts

Coverage	Enroll or Decline ¹	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Voluntary Term Life: Dep Children (Coverage subject to election of employee or spouse Term Life)	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	\$0.79 \$1.19 \$1.59 \$1.99

¹"Enroll" authorizes employer to payroll deduct premiums.

²Statement of Health may be required.

Employee/Member Name	Date of Birth
----------------------	---------------

Health Questions

Answer all questions on this page for each person being underwritten for insurance. For any "Yes" answer (other than for question 3A), underline the condition and record details in the space provided on the next page. Failure to provide details of a condition will cause a delay in the review of your application.

This Section applies to:

- 1) late applicants;
- 2) those electing a benefit increase* or benefit over the guaranteed issue amount;
- 3) any person who has had a previous application to Reliance Standard coverage rejected and is re-applying**
- 4) any person who has had a previous Reliance Standard coverage voluntarily terminated and wishes to have coverage again**.

*Unless the benefit increase election is during an open enrollment period

**In both cases, a person must answer the health questions, even during an open enrollment period.

	EMPLOYEE	SPOUSE
Enter height and weight.	Ht. ___ft. ___in. Wt. _____ lbs	Ht. ___ft. ___in. Wt. _____ lbs
1. In the past 10 years, have you or your spouse been treated for or diagnosed by a licensed medical provider as having: heart, liver (biliary cirrhosis) or kidney disorder; an abnormal colonoscopy requiring follow-up; neurological disorder; diabetes; high blood pressure; thyroid disorder; stroke; transient ischemic attack (TIA); cancer and/or tumor malignant or benign; mental or nervous disorder; or been advised to have treatment for drug abuse (illegal or prescription drugs) or alcoholism?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 10 years, have you or your spouse been diagnosed by a licensed medical provider with or treated for: chronic pain; arthritis (lupus, rheumatoid or osteoarthritis); musculoskeletal (back, neck or muscle) condition; respiratory disorder including asthma, chronic obstructive pulmonary disease (COPD); or emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or your spouse in the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); or lymphadenopathy (enlarged or swollen glands)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3A. Have you or your spouse in the past 10 years been tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed by a licensed medical provider as having ARC (AIDS-related complex) or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 10 years, have you or your spouse: (a) consulted with or been examined or treated by a physician, practitioner or specialist (include routine physicals only when there is an existing or newly diagnosed medical condition)? (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation? or (c) been prescribed medication(s) (other than for colds, flu or allergies)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you or your spouse currently under medical care by a licensed member of the medical profession for pregnancy or diagnosed as being pregnant? In the past 10 years, have you or your spouse been diagnosed by a licensed medical provider with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee/Member Primary Care Physician's Full Name	Office Phone Number
Address	
Spouse Primary Care Physician's Full Name	Office Phone Number
Address	

Employee/Member Name	Date of Birth
----------------------	---------------

Details

Please provide all names used for medical records (if different than the names provided on this form): _____

For each "Yes" response to a health question, please provide details below.

DO NOT PROVIDE ANY DETAILS FOR A "YES" ANSWER TO QUESTION 3A.

Question #	Illness or Nature of Injury	Date	Physician's Full Name and Address (if different than Primary)	Check One	
				Employee	Spouse

If you need more space, check here . Complete, sign and date a separate sheet of paper and attach it to this page.

Read, Sign and Date Below

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. 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 an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next.
- If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of the "Designation of Beneficiary" form and "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices". If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy will determine to whom benefits, if any, will be payable.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the MIB, Inc. to release any information or record(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 of my personal health information to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I (or my authorized representative) will be sent a copy of this Authorization upon request.

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable,) have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X _____ Employee's/Member's Signature (required at all times)	_____ Date	X _____ Spouse's Signature (required if spouse Statement of Health required)	_____ Date
---------------------------------------------------------------------	------------	------------------------------------------------------------------------------------	------------

RELIANCE STANDARD

LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

Designation of Beneficiary

Policyholder	Policy Number(s)
Insured Name	Social Security Number

I hereby designate the following as my beneficiary (ies) under the above policy number(s):

Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally between all contingent beneficiaries.

- ◆ This beneficiary designation revokes all revocable prior beneficiary designations.
- ◆ Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class (primary or contingent).
- ◆ If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured
------	----------------------

Important Information Regarding Applications for Insurance

The information provided on the Enrollment and Statement of Health form will be used in determining the insurability of a person proposed for insurance. Responsible parties completing and submitting a Statement of Health form are required to be made aware of the following statements concerning the consequences of insurance fraud. The lack of an applicable statement shall not constitute a defense against penalties.

ARKANSAS and LOUISIANA — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **COLORADO** — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **FLORIDA** — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **KENTUCKY** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **MAINE** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MARYLAND** — Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NEW JERSEY** — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NEW MEXICO** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NEW YORK** (health insurance only) — 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. **OHIO** — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **PENNSYLVANIA** — 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 subjects such person to criminal and civil penalties. **RHODE ISLAND** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **TENNESSEE, VIRGINIA, WASHINGTON** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **WASHINGTON, DC** — **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KEEP THIS INFORMATION PAGE FOR YOUR RECORDS.

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

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

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 MIB, Inc.

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 via its website (www.mib.com) or 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. 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 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

KEEP THIS NOTICE FOR YOUR RECORDS.

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

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