Plan Highlights

Voluntary Group Term Life Insurance

Department of Education

ELIGIBILITY

Employees: Each Active, Full-time employee working 30 or more hours per week, except any person working on a temporary or seasonal basis.
Dependents: You or your spouse must be insured in order for Dependent children to be covered.
Dependents are:

- Your legal spouse or domestic partner under age 70. Spouse coverage terminates at age 75.
- Your unmarried financially dependent children* age 14 days to 20 years (to 26 years if full-time student).

*natural and adopted children upon finalization of adoption; stepchildren and foster children living with you.
Age limit does not apply to handicapped children.
A person may not have coverage as both an Employee and Dependent.
Only one insured spouse may cover Dependent children.

BENEFIT AMOUNT

Employee and Spouse: Choose from a minimum of $10,000 to a maximum of $500,000 (in $10,000 increments) for yourself and/or your spouse. The benefit amounts chosen need not be the same.

Eligible Dependent Child(ren): 14 Days to 6 months: $1,000
Age 6 months to 20 years of age (26, if full-time student): choice of $2,500, $5,000; $7,500 or $10,000

Choose one benefit amount for all eligible children in family.

GUARANTEED ISSUE (INITIAL ELIGIBILITY PERIOD ONLY)

Employee:
Under age 60: $100,000
Age 60 but under age 70: $20,000
Age 70 or older: none
Spouse:
Under age 60: $20,000 (requires you to apply for at least $50,000 for yourself)
Age 60 or older: none
GUARANTEED ISSUE is subject to underwriting rules and is not available in all circumstances.

CONTRIBUTION REQUIREMENTS

Coverage is employee paid.

BENEFIT REDUCTION DUE TO AGE (applicable to employee coverage)

AT AGE	FACE AMOUNT REDUCES TO:
75-79	60% of available or in force amount at age 74
80-84	35% of available or in force amount at age 74
85-89	27.5% of available or in force amount at age 74
90-94	20% of available or in force amount at age 74
95-99	7.5% of available or in force amount at age 74
100 +	5% of available or in force amount at age 74

RATE

See attached Rate Sheet.

FEATURES

- Conversion Privilege
- FMLA/MSLA Continuation
- Portability
- Waiver of Premium

EXCLUSIONS

Death by suicide is not covered during the first two years an insured's 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.

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-8349, et al.

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. Do the same thing for your spouse at his/her age for the number of units desired. If you have used any form of tobacco in the last 12 months, you will be considered a 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	3.98
50-54	13.50	6.40
55-59	18.66	9.92
60-64	29.82	18.13
65-69	39.48	26.68
70 and Over*	59.28	43.26

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

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

Reliance Standard Life Insurance Company
Enrollment and Statement of Health

Name of Employer Department of Education			Location/Division	Bill Group 000001
Policy # and Class # VGTL176653 / 1	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:
Lois Goode
rsmith4796@aol.com or

Richard Smith & Associates, Inc.
1824 Miccosukee Commons Dr.
Tallahassee, FL 32308

We do not accept faxed forms.

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				

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 ☐ Yes ☐ No	Child Name	Date of Birth	Handicapped ☐ Yes ☐ No
Child Name	Date of Birth	Handicapped ☐ Yes ☐ No	Child Name	Date of Birth	Handicapped ☐ Yes ☐ 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]	☐ Enroll ☐ Decline			☐ $20,000 ☐ $40,000 ☐ $60,000 ☐ $80,000 ☐ $100,000 ☐ Other______	See Premium Table

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: Spouse[2]	☐ Enroll ☐ Decline			☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ Other______	See Premium Table
Voluntary Term Life: Dep Children (Coverage subject to election of employee or spouse Term Life)	☐ Enroll ☐ Decline			☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000	$0.79 $1.19 $1.59 $1.99

[1]"Enroll" authorizes employer to payroll deduct premiums.
[2]Statement 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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)?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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)?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are youor 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?	☐ Yes ☐ No	☐ Yes ☐ 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 or 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

Licensed Florida Agent Lois Goode Licensed Florida Agent Number A100436

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 Heath 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 your: (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.

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

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