

This form is to be used only when a person desires and is eligible to port Term Life Insurance. This form must be completed in full and submitted to The Company within 31 days following the date of termination. SEND TO: Reliance Standard Life Insurance Company, Premium Billing and Collection, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090.

**VERIFICATION OF INSURED PERSON'S ELIGIBILITY TO PORT TERM LIFE INSURANCE**

To Be Completed By Policyholder/Participating Unit  Male  Female

1. Insured Person's full name \_\_\_\_\_ (Please Print)      2. Soc. Sec. Number \_\_\_\_\_

3. Name of Policyholder/Participating Unit \_\_\_\_\_      4. Policyholder/Participating Unit No.: \_\_\_\_\_

5. Branch or Location (if different from 3.) \_\_\_\_\_

6. Date Employed: \_\_\_\_\_ Salary: \_\_\_\_\_ Date Last Salary Change: \_\_\_\_\_ Class: \_\_\_\_\_

7. Effective Date of Coverage: Employee: \_\_\_\_\_ Spouse, if any: \_\_\_\_\_ Children, if any: \_\_\_\_\_

8. Occupation/Job Title \_\_\_\_\_      9. Date Person Last Worked \_\_\_\_\_

10. Date Employment Terminated (if different from 9.) \_\_\_\_\_

11. If (9) and (10) differ, please explain \_\_\_\_\_

12. Amount of Term Life Insurance (including the amount of any AD&D rider coverage, if applicable) in force under the Policy on date of termination: Employee \$ \_\_\_\_\_ Spouse, if any \$ \_\_\_\_\_ Children, if any \$ \_\_\_\_\_

13. Verified by \_\_\_\_\_ (Signed by authorized individual)      Date \_\_\_\_\_      Phone Number \_\_\_\_\_

To Be Completed By Applicant

Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Date of Birth: Employee: \_\_\_\_\_ Spouse, if any \_\_\_\_\_ Children, if any \_\_\_\_\_

Amount of Coverage Desired (must be equal to or less than amount in force): may not exceed \$500,000 from all Reliance Standard Life/AD&D coverage combined):

Employee: \$ \_\_\_\_\_ Spouse, if any: \$ \_\_\_\_\_ Children, if any: \$ \_\_\_\_\_

Beneficiary:

Full Name(s)	Relationship	Percent of Proceeds	SSN
_____	_____	_____	_____
_____	_____	_____	_____

Signature of Applicant \_\_\_\_\_      Email Address \_\_\_\_\_      Phone Number \_\_\_\_\_      Date Signed \_\_\_\_\_