RELIASTAR

ReliaStar Life Insurance Company

Enrollment/New Hire/Change Form

INSTRUCTIONS: White portion to be completed by the Employee. Shaded portion to be completed by the Employer/Plan Sponsor. Print clearly in dark ink, sign the form, and return as instructed. ***** Refer to reverse side of form for a description of these fields.***

NAME OF EMPLOYER/PLAN SPONSOR	GROUP/PLAN NUMBER	ACCOUNT NUMBER/
County of Stanislaus	GL,H-31640-7	LOCATION #50

This change is due to: *(Check all that apply)*			EFFECTIVE DATE OF COVERAGE/DATE OF CHANGE	DATE OF HIRE
__Initial Enrollment	__Address Change	__Termination	/ /	/ /
__Regular Enrollee** (New Hire)	__Late Entrant** (Life, LTD, and STD)	__Other:_____		

SECTION 1. Employee Information. *If additional space is required, complete and attach a separate sheet of paper (signed and dated).*

EMPLOYEE NAME *(last, first, middle initial)*		μ FEMALE μ MALE	DATE OF BIRTH / /	SOCIAL SECURITY #	EMPLOYEE I.D. #
MARITAL STATUS **	JOB TITLE OR OCCUPATION	ANNUAL SALARY	EMPLOYMENT STATUS: __ Active Full-Time __ Active Part-Time __ Retired		
EMPLOYEE ADDRESS *(street address, city, state, zip code)*			TELEPHONE Work ( ) Home ( )		

SECTION 2. Coverage Selection - Elect Coverage Amount

BASIC LIFE *(Note: Basic life insurance is employer provided)*	☐ All Active Full-Time Employees, except County Attorneys, Department Heads, Management, Confidential Employees and Resident Physicians ☐ Early Retirees ☐ County Attorneys ☐ Department Heads and Management Employees ☐ Confidential Employees ☐ Resident Physicians ☐ Stanislaus Consolidated Fire Protection District

BASIC AD&D *(Note: Basic AD&D insurance is employer provided)*	☐ County Attorneys ☐ Department Heads and Management Employees ☐ Resident Physicians

(For Employee Only) SUPPLEMENTAL LIFE/AD&D	Elect Coverage Amount *(Evidence of Insurability required for amounts over $100,000)* (100% employee paid) ☐Option 1: $20,000 ☐Option 2: $30,000 ☐Option 3: $50,000 ☐Option 4: $100,000 ☐Option 5: $150,000 ☐Option 6: $200,000 ☐Option 7: $250,000 ☐Option 8: $300,000	☐Waive Coverage

LONG-TERM DISABILITY	☐All Management Employees Only *(Note: Long-term disability insurance is employer provided.)*

SECTION 3. Beneficiary Information. *Complete if Life/ADD coverage was selected. If additional space is required, complete and attach a separate sheet of paper.*

BENEFICIARY INFORMATION ** *List one or more beneficiaries below.*	BENEFICIARY'S SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE	BENEFICIARY'S DATE OF BIRTH	PERCENT OF BENEFIT *(MUST add up to 100%)*
PRIMARY:				
SECONDARY:				

READ THE REVERSE SIDE AND THEN SIGN AND DATE BELOW τ

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I have read and understand the authorization, included on this form, and consent to its terms. Also, subject to revocation by me by written notice to my employer, I request the coverage provided from time to time by my employer's group plan(s), as elected on this form, and authorize the required deduction (if any) from my wages.

Employee's Signature	Date Signed	Signature or Name of Benefits Person	Date Signed
	/ /		/ /

AUTHORIZATION TO RELEASE INFORMATION TO RELIASTAR LIFE

I give permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), employer, or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, or surgery as they apply to me, my spouse, or any of my children who are to be covered.

LIMITATIONS, if any:

I understand that all or part of this information may be communicated between ReliaStar Life and its affiliates and may be sent to MIB, Inc. It may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I give my permission to ReliaStar Life to get any and all medical record information for the purposes described in this form. I specifically consent to the redisclosure of medical record information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand that my additional written consent will be required before any information described above may be given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original.

FOR LIFE INSURANCE ONLY

As it relates to the incontestability clause, this form will be valid for 30 months from the date this form is signed or for two years from the date coverage is made effective, whichever is earlier.

FRAUD WARNING STATEMENT

Any person who knowingly and with intent to defraud, files a statement of claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

INSTRUCTIONS FOR ** FIELDS ON THIS FORM

Beneficiary Information **	Use this section to designate your life insurance benefit to your beneficiary(ies). Beneficiaries may include your spouse, children, parents, charities or anyone you wish. If you are listing an estate, specify whose estate.
Late Entrant ** (Life, LTD, and STD)	A late entrant is an individual who is enrolling for Life, LTD, and STD coverage after the first available opportunity.
Marital Status **	Enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.
Regular Enrollee **	A regular enrollee is a new employee (this may or may not include dependents) just hired and enrolling into the plan at the first available opportunity (within 31 days of date of hire).

FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	EMPLOYEE BASIC LIFE/BASIC AD&D	EMPLOYEE SUPPLEMENTAL LIFE/AD&D	LTD
CLASS			
AMOUNT			
PREMIUM			