RELIANCE STANDARD

LIFE INSURANCE COMPANY

BasicCare Program

Enrollment Form

A MEMBER OF THE TOKIO MARINE GROUP

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.

RECTION B — ENROLLMENT SELECTION Is important that you follow the directions when making your elections; otherwise, your enrollment may be delayed. And if you are your of your dependents (spouse or children), please be sure to include their information in Section C; otherwise, their enrollmed layed. Costs listed below are weekly amounts. BasicAdvantage Total & Essential Plans Dental Plan Term Life / STD Plans Imployee Only \$16.88 \$4.45 \$4.25 Imployee + Spouse \$38.09	P P O R T U N I Name of Employ CTION B — ENF	Home Phone Number T I E S I N	Work Phone Number	Sex: M
The property of the back of this form. The property of the property of the back of this form. Part P	P P O R T U N I Name of Employ CTION B — ENF	T I E S I N	Work Phone Number	
Essential Plans¹ Dental Plan Term Life / STD Plan Employee Only	important that you follow t	OLLMENT SELECTION		
Employee Only	yed. Costs listed below are e your selection by putting	weekly amounts. an X in the box next to the selecti		
Employee + Spouse	Salta Salta	Essential Plans ¹	Dental Plan	Term Life / STD Plans ²
	ployee Only	\$ 16.88	□ \$4.45	□ \$4.25
Employee + One Child	ployee + Spouse	\$ 38.09		
		C 420.75		
Employee + Children	oloyee + One Child	□ \$29.75		
Employee + Family				
DECLINE COVERAGE	ployee + Children	□ \$52.01	☐ \$12.75	□ \$ 4.45

(OVER PLEASE)

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- SECTION C — WHICH DEPENDENTS WILL BE COVERED?				
SECTION C — WHICH DEPENDENTS WILL	DE COVERED:			
1. First Name Middle Initial	ast Name			
Sex: M F Enrolled in the following plans: BasicAdvantage Total & Essential Plans Dental Plan Term Life Plan				
	Relationship:			
Birth Date: Month Day Year	If over 25, is your child:			
Social Security #:	Check the box here 🔲 if living at a different address and list below.			
	ast Name			
Sex: M F Enrolled in the following plans: BasicAdvantage Total & Essential f	Plans Dental Plan Term Life Plan			
	Relationship: Your Spouse Your Child			
Birth Date: Month Day Year	If over 25, is your child: Disabled			
Social Security #:	Check the box here ☐ if living at a different address and list below.			
3. First Name Middle Initial	ust Name			
Sex: M F Enrolled in the following plans: BasicAdvantage Total & Essential Plans Dental Plan Term Life Plan				
Birth Date: Month Day Year	Relationship:			
Social Security #:	Check the box here if living at a different address and list below.			
4. First Name Middle Initial	ast Name			
Sex: M F Enrolled in the following plans: BasicAdvantage Total & Essential				
	Relationship:			
Birth Date: Month Day Year	If over 25, is your child: Disabled			
Social Security #:	Check the box here ☐ if living at a different address and list below.			
Address of Dependent not living with you:				
First Name Middle Initial Last Nar	ne e			
Mailing Address: Street	City State Zip			
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.				
There may be events that will allow you to enroll yourself and your eligible dependents outside of the Open Enrollment Periods. Please ask your employer for a Life Event Change Form which must be used for the additions or changes to benefits (including Special Enrollments), outside of an Open Enrollment Period.				

RELIANCE STANDARD

All Plans underwritten by Reliance Standard Life Insurance Company

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